Israeli and Palestinian Health Care Reforms

Proceedings of a Seminar
Jerusalem, October 31, 1994

Editors: Tamara Barnea and Dena Asfour

American Jewish Joint Distribution Committee
JDC-Brookdale Institute

in cooperation with

Palestinian Council of Health
Israeli Ministry of Health

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April 1995

JDC-Brookdale Institute of Gerontology
and Human Development
P.O.B. 13087
Jerusalem 91130, Israel
Tel. 972-2-6557400
Fax. 972-2-635851

Introduction

At a time when health care reforms are being implemented in many countries, both the Israeli and the Palestinian health care systems are undergoing dramatic changes. A seminar which took place in Jerusalem in October 1994 enabled professionals in the two systems to exchange information and ideas, deepening their understanding of the difficulties each system is facing, and contributing to the decision-making process.

The one-day seminar on "Israeli and Palestinian Health Care Reforms" was organized by JDC-Israel and the JDC-Brookdale Institute in cooperation with the Palestinian Council of Health and the Israeli Ministry of Health. The goal of the seminar was to enable Israeli and Palestinian health care professionals to share their experiences of health policy formulation, and of planning and implementing health care reforms. In addition, it was hoped that the seminar would encourage mutual cooperation in promoting improved health care in the region.

The seminar was conducted in English, and held at the JDC-Brookdale Institute in Jerusalem. There were seventy-six participants: 22 Palestinians, 25 Israelis, 19 representatives of the AJJDC, and 10 representatives -- local and from overseas -- of international organizations involved in funding health care services in the West Bank and Gaza (USAID, the World Bank, the World Health Organization, and the Italian government). The participants included policy-makers, service providers, researchers and academics.

The seminar opened with greetings from Dr. Ephraim Sneh, the Israeli Minister of Health, Dr. Riad Zanoun, Minister of Health for the Palestinian Authority, and Dr. Martin Cherkasky, Honorary Vice-President of the AJJDC. These were followed by a plenary session, in which two keynote presentations were made: a description of the Palestinian Health Plan from Dr. Rafiq Husseini, Director of the Palestinian Council of Health and Assistant-Deputy Minister of Health for the Palestinian Authority; and a description of the recent Israeli health care reforms from Prof. Mordechai Shani, Director-General of the Israeli Ministry of Health.

In the afternoon, four working groups met to discuss the following topics: Reorganization of the Israeli Ministry of Health; Health Insurance; the Service Provision System; and the Quality of Health Care. The purpose of the working groups was to facilitate an in-depth understanding of issues of major interest, and to enable the participants to interact professionally and personally

in a supportive framework. Each working group was chaired by two co-chairpersons, one Palestinian and one Israeli, who decided upon the material for discussion, and a joint strategy for leading the group, prior to the seminar.

The seminar ended with a plenary session in which the co-chairpersons of the working groups summarized the discussions in the four groups, and final questions were raised and answered.

The seminar participants were provided with background material on the Palestinian and Israeli health care systems, and on the issues discussed in the working groups.

Judging by the comments made by participants during the seminar and in evaluation forms completed afterwards, the seminar achieved its goals. It enabled participants to become better acquainted with the Israeli and the Palestinian health care systems, to exchange ideas on health policy affecting the two systems, and to initiate a process in which professionals and organizations will continue to "learn together".

In addition, the seminar provided a unique opportunity for Israelis and Palestinians to interact with the "other side" on a personal level. Participants voiced their appreciation of the open and friendly atmosphere created during the seminar, and Palestinians and Israelis alike expressed a wish for future cooperative activities.

Tamara Barnea Dena Asfour

Acknowledgments

Our gratitude and appreciation is extended to the organizations which organized the Israeli-Palestinian Seminar on Health Care Reforms: the Palestinian Council of Health, the Israeli Ministry of Health, the American Jewish Joint Distribution Committee (AJJDC), JDC-Israel, and the JDC-Brookdale Institute.

We wish to acknowledge the valuable contribution of those individuals who delivered opening greetings and gave keynote presentations at the seminar: *Dr. Ephraim Sneh*, the Israeli Minister of Health; *Dr. Riad Zanoun*, the Palestinian Minister of Health; *Prof. Martin Cherkasky*, Honorary Vice-President of the AJJDC; *Dr. Rafiq Husseini*, Director of the Palestinian Council of Health and Assistant Deputy Minister of Health for the Palestinian Authority; and *Prof. Mordechai Shani*, Director-General of the Israeli Ministry of Health.

Our thanks to the co-chairpersons of the four working groups, who devoted considerable time and effort to preparatory work and whose contribution to the seminar is greatly appreciated: *Dr. Yehia Abed*, Coordinator of the Central Units of the Palestinian Council of Health in Gaza, and Director of the Gaza Health Services Research Center; *Gabi Bin-Nun*, Deputy Director-General for Health Economics at the Israeli Ministry of Health; *Dr. Bruce Rosen*, Coordinator of the Health Policy Research Program at the JDC-Brookdale Institute; *Dr. Adnan Hammad*, Senior Health Planner at the Planning and Research Center; *Dr. Nadeem Toubassi*, Director-General of the Palestinian Health Authority; *Dr. Yitzhak Peterburg*, Executive Director of Kupat Holim Clalit, Central District; *Prof. Leon Epstein*, Head of the Department of Social Medicine at the Hadassah Medical Center; and *Dr. Rashad Massoud*, Coordinator of the Quality of Health Care Unit of the Palestinian Council of Health.

We would like to thank *Prof. Jack Habib*, Director of JDC-Israel and Director of the JDC-Brookdale Institute, for assisting with the seminar program and for chairing the discussions.

We would like to thank the seminar participants -- Palestinians, Israelis, and representatives of international organizations -- for their contribution during the seminar, and for the encouragement and support they expressed for the possibility of continued professional collaboration.

Finally, our thanks to *Galina Lane* and *Marsha Weinstein*, who prepared the proceedings for publication.

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The following individuals assisted in the organization of the seminar: *Dena Asfour* and *Hossam Sharkawi* of the International Cooperation Unit of the Palestinian Council of Health; and *Tamara Barnea*, *Dr. Bruce Rosen*, *Meira Aboulafia* and *Natalie Budwig* of the JDC-Brookdale Institute.

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Greetings

Tamara Barnea, *Coordinator of the AJJDC's Israeli-Palestinian-Arab Program*: Good morning ladies and gentlemen: Your excellency, the Israeli Minister of Health, Dr. Ephraim Sneh; your excellency, the Minister of Health for the Palestinian Authority, Dr. Riad Zanoun; Dr. Martin Cherkasky, Honorary Vice President of the American Jewish Joint Distribution Committee (AJJDC); Prof. Jack Habib, Director of JDC-Israel and the JDC-Brookdale Institute; international representatives from the Italian Government, USAID, the WHO and the World Bank; distinguished guests, colleagues and friends. I am privileged and honored to open the Israeli and Palestinian Health Care Reforms Seminar. On behalf of the AJJDC and the JDC-Brookdale Institute, I would like to welcome you all: أهلا وسهلا ברוכים הבאים

Dr. Ephraim Sneh, *Minister of Health, Israel*

My Palestinian colleague, Dr. Zanoun; Dr. Cherkasky; Prof. Habib; Ms. Barnea; honored guests: Good morning. First, I would like to congratulate the JDC-Brookdale Institute for organizing this seminar. I think it characterizes the mode of activity of this Institute, where the profile is low but the quality is high. I think that the best way to promote Israeli-Palestinian cooperation is through a quiet, highly professional seminar such as this. I'm sure this day will be both fruitful and successful.

I would like to address Dr. Zanoun and my Palestinian colleagues, and say that from a certain point of view, I don't envy you. I don't envy you because I know how tough it is to run a public health care system in a society with a GDP of $13,000 per capita. So I can imagine how tough it is to try to run a system in a society where the resources are far slimmer. But, I envy you in one respect. You now have the opportunity to build everything from the beginning. This is a great undertaking, one which I hope you will achieve.

I would like to say a few words about how I envisage Israeli-Palestinian cooperation in the domain of medicine and health care. As an allergist, I'm sensitive to all the sensitivities which exist; but we have to admit that the level of medical services in Israel is one of the highest in the world, and I'm very proud of that. You have to go a long way in order to reach that level and we have to help you do that in an appropriate way, because one of the fundamentals of a "healthy" society is an adequate, efficient health care system.

I am in favor of one main avenue of cooperation, which is to enable Palestinian medical teams to be trained in Israeli medical centers in order to acquire specialties and skills which at present you don't have. I know, for instance, that in pediatric surgery, pediatric intensive care, neurosurgery and a number of other fields, the need for training is very urgent. I personally will try to do my utmost to acquire the financing for this training. In my experience, Israelis and Palestinians work very well together and learn much from each other on a professional basis. I think the training will be successful and, in a relatively short period of time, should give you the option of opening most of the specialist departments needed in your hospitals in the West Bank and the Gaza Strip. In the meantime, all Israeli hospitals and specialist departments are open to Palestinian patients. As you know, we have reduced the price of treatment so that it is now on a par with the price for an Israeli patient. You of course have the option to bargain for better prices; but the doors are open, and everything required to facilitate the comfort of Palestinian patients will be done.

I believe that serious and fruitful cooperation will develop between Israeli and Palestinian doctors, involving joint staff meetings, agreements between hospitals in the West Bank and Gaza and in Israel, and I believe that this will be a very sound bridge for peace.

As the peace process progresses, we will be able to establish medical links and relationships between Israel, the Palestinian Authority and other Middle Eastern countries. In some fields, for instance organ transplantation, I believe we can achieve certain goals even in the short term. We watch with concern as you go about the process of building your own authorities. People who want peace consider the success of the Palestinian Authority as their own success. Failure would be considered not only a disaster for you, but a disaster for us. We are very eager to see you succeed in the best possible way. That is why we are trying to help without imposing ourselves on you. I hope that I don't sound patronizing. We are trying to help you, because we are aware of the dangers that the Palestinian Authority is facing. A most prominent and dreadful example is that of Algeria. In all my talks with Palestinian friends, I remind them of Algeria. Why? Because the independent Algeria which started out with such high credit to the national liberation movement (the F.L.N.) has deteriorated into the Algeria we know today. The prescription for this sort of deterioration is an autocratic regime, economic incompetence and corruption. You should be aware of the dangers of such deterioration and thoroughly learn from the Algerian example.

Please don't misinterpret my remarks. I say these things out of a deep and sincere concern, knowing that you are now in a very critical phase, and that the enemies of peace, and those who want to reduce Palestinian society to the level of medieval times, are waiting for your failure. I have stated time and again that we at the Israeli Ministry of Health and in the Israeli medical community will give our support for whatever is needed for your health care system to succeed. This support will be provided to you wholeheartedly. I wish you success, and I hope that this seminar, which has been so well-organized by the JDC-Brookdale Institute, will be one step in the right direction.

Dr. Riad Zanoun, *Minister of Health, Palestinian Authority*

Your excellency, Minister and friend -- good friend -- Dr. Ephraim Sneh; Dr. Martin Cherkasky, Honorary Vice-President of the AJJDC; distinguished participants, ladies and gentlemen.

Thanks to the AJJDC for organizing this seminar. Open-hearted, open-minded we are here, away from politics at least for some time, away from action and overreaction, away from the killing of innocents that we condemn, and over which we feel great sorrow and sadness for such blood-shedding and destruction. Such overreaction put 2.4 million Palestinians in jail. Our coming here is exceptional and due to the special efforts of Dr. Sneh, whom we thank.

We are here to discuss health reform, to give better quality of life to human beings. Israeli or Palestinian, no difference; because we are quite sure that in our blood vessels run the same plasma constituents, and the same red and white blood corpuscles.

Health reform can only be achieved by intimate cooperation between yourselves and ourselves. Epidemics, bacteria, viruses, air pollution, sea pollution do not respect borders. The air and the Mediterranean Sea remind us that nature, the earth and sky, unify us.

Yes, we are here to replace hatred and enmity with love and cooperation: destruction with construction, killing with life-saving and disease with health.

In mid-May 1994, the fertilized ovum of the peace accord started its journey in the Gaza Strip, threatened by abortion. We were told that 30,000 weapons

were in the hands of Hamas, Jehad, Fatah and others, and that a civil war would start in Afghani, Somali or Algerian fashion. You just choose the fashion. By the third month, a New York journalist told me: you have escaped the "civil war" but the inevitable "abortion" is coming soon. "You are too nice to succeed", he said; "the health care challenges are so complicated that we fear the collapse of health services is inevitable. It is just a matter of time, especially in the absence of finance from the donor countries". We accepted the challenge, our back to the wall. We don't have much to lose.

At the beginning of June, we began operating primary health care centers with an additional seven hours from three o'clock to ten o'clock (in the afternoon and early evening). This was to relieve the congestion and overcrowding of our hospitals that occurs following closure at noon of all the medical clinics, the morning medical clinics.

By the beginning of September, 100 physicians, 100 nurses, and 100 technicians and laborers were recruited from among the unemployed to work in our hospitals and primary health care centers to support the existing manpower. Dr. Fatin, a gynecologist in the Shifa Government Hospital, was about to collapse from exhaustion at midnight when I asked her what's wrong. She said: "I am supervising the cases of 25 giving birth tonight". "Are you alone?" "Yes". "No colleague with you?" "No". Now, after we added the 300 employees, Dr. Fatin received three additional doctors, three additional staff nurses and three additional cleaners.

In mid-September, we started to direct medical teams to schools to screen 25,000 first-year primary students. By so doing, we started school health services for the first time in the last 30 years. We also started psychology/mental health and dental health in schools. We used to hear about what was done in different countries, but this was never applied in our schools. We were supposed to receive a budget of $1 million from the European Community, and we received nothing for school health programs. After implementing our plan in three weeks, we discovered that it is possible to accomplish basic health screening by use of a tongue depressor, a stethoscope and an eye chart, as well as by determination, commitment, dedication and empty pockets. We discovered that the poor have more time to do things, more achievements to fulfill, and that they care more.

At the beginning of June 1994, we took the first painful decision that community health insurance must be obligatory for everybody. There were

people with high expectations in the Palestine Health Authority, expecting honey and money to be distributed, but never expecting to pay for their health services. But we chose the tough decision, and it worked. Today, 65,000 families are participating in the national health insurance scheme. This compares with 35,000 people in April 1994.

Our income from the national health insurance now covers 50% of our total health expenditure in cash. We expect, with the help of our friend Dr. Sneh and all our friends who understand us, to get our share from the laborers' health insurance. There are the 25,000 to 30,000 who work in Israel. We care for their families but we don't receive their premiums from the National Insurance Institute (NII). With this money we'll be able to cover the cost of medicines and disposables for the whole Gaza Strip.

We now have the responsibility of caring for 11,000 prisoners and ex-detainees and their families who have been set free, as well as 5,000 returnees and their families held by either police or security. Of course, nobody pays us for taking care of them, but we record the bills in our notebooks hoping that when we receive funds (promised last October by the European Community donor countries, and the International Labor Organization), this will help to cover the cost of health insurance for these families.

Maybe you experienced this in 1948: little money, and increasing numbers of returnees and big responsibilities. We are here to share experiences and advice. We know you have vast experience and we know that not only his excellency, the Minister, but also all our friends here, are keen enough and will help us. Dr. Sneh, you probably remember, in our first meeting you spoke about training for Palestinian health care personnel. At that time, I can honestly tell you, I looked on that like a dream, but today I can say that 25 trainee physicians, staff nurses, and nurses have completed their training at the Soroka Hospital, Beersheva. They came back, and we are happy with them, and happy with the knowledge they brought.

We have, as well, the five teams you have already arranged. We sent you all the details about them, and you are helping in planning the logistics, as well as helping find the funding. Now another group of colleagues is going to Ichilov Hospital, Tel Aviv, for six to twelve months. This was achieved through a Danish newspaper, which made an appeal on our behalf. It was interesting that people responded nicely to support the march of peace. The journalist told me that some people sent donations of $550, and some $1,000,

for that fund. In the Hadassah School of Public Health, we have a senior colleague studying health economics and health insurance.

We have a saying in Arabic, that the poor man can gain half of the whole world if he begs nicely. Ladies and gentlemen, history will always write about such meetings, because we are here to organize and plan health reforms for the benefit of human beings -- Israelis and Palestinians sharing so many common things -- without regard for nationality, gender, or religion. Love, cooperation and care for the health of people who decided to live in peace. This is our opinion, our choice. We are determined, insistent to complete this march.

Dr. Martin Cherkasky, *Honorary Vice-President of the AJJDC*

Health Minister Zanoun, Health Minister Sneh, conference colleagues. Before I make my remarks, I'd like to comment on what we have just heard from the Health Minister of Israel and the Health Minister of the Palestinian Authority. Remember, I'm an outsider from another place, with a deep interest in the health and welfare of all the peoples who live in this part of the world, and I was enormously impressed with Health Minister Sneh's broad, compassionate statement of intent to play a major role in the development of the new Palestinian entity. It was a passionate and compassionate statement and, this outsider believes, what the policy of the State of Israel ought to be. I must say to you that Dr. Zanoun's statement was also a revelation. I wish I could persuade my colleagues in America that you can do these wonderful things without money in your pockets. When you think of all the obstacles and difficulties and chaos and uncertainty that exist, the things that you tell us you've already accomplished are remarkable and sustaining. I think the statements of these two health ministers indicate that if we do the rest of it right, we are really going to make a contribution to the health and welfare of the people of this area and to peace.

At any time, this would be a remarkable gathering. At a time of such uncertainty, and given recent events, I welcome you with a sense of gratitude and awe. I carry to you the greetings and thanks of Ambassador Milton Wolf, President of the American Jewish Joint Distribution Committee (AJJDC), and Michael Schneider, Executive Vice-President of the AJJDC. Let me tell you a word or two about the AJJDC.

In addition to our work with Jewish communities in 50 countries, we operate an international development program that engages in non-sectarian emergency

relief and development projects in countries throughout the world. Wherever possible, the AJJDC works closely with professionals in the region who are familiar with local needs and strengths. Today's seminar, a cooperative effort based on an interchange of knowledge and expertise, is the way we like to go about things.

JDC-Israel and the Palestinian community are engaged in other collaborative projects. In the fall of 1993, I came to Jerusalem to participate in a conference organized by the AJJDC with the Alumni Association of Harvard Institute for Social and Economic Policy in the Middle East. The subject of the conference was the implementation of Total Quality Management in Middle Eastern hospitals and health centers. Health care professionals from Israel, Egypt, the West Bank and Gaza attended.

As a follow-up to that conference, we expect to establish a program some time in early 1995 to provide further training and to create a regional network of health care organizations, all implementing quality management. During the last few months, representatives of the Palestinian Council of Health and JDC-Israel have worked together to design a program intended "to improve the health and quality of life of Palestinian children in Gaza and the West Bank". This will be achieved by teaching and encouraging healthy habits among elementary school children and their parents, and by showing them how to prevent both accidents and illness.

I love to go to conferences, and we need to do a lot of talking and sharing, but at some point we've got to do some work. This week, we shall formally launch the health education program, while pursuing additional finance and partners.

The three people vital to the development of this program are Dr. Yehia Abed, Director of the Gaza Health Services Research Center and a member of the Palestinian Council of Health; Prof. Ted Tulchinsky, of the Israeli Ministry of Health; and Tamara Barnea, of JDC-Israel and the JDC-Brookdale Institute.

Before we turn to the business of the day, I would like to thank all those responsible for the hard work of arranging this remarkable meeting. My gratitude goes to the Palestinian Council of Health and the Israeli Ministry of Health for their cooperation. The two health ministers, Dr. Riad Zanoun and Dr. Ephraim Sneh, have been gracious and helpful. I would like to thank all of our speakers, including Prof. Jack Habib, Director of the AJJDC in Israel, who will chair this morning's meeting. We will hear from Dr. Rafiq

Husseini, Director of the Palestinian Council of Health and Assistant Deputy-Minister of Health for the Palestinian Authority, and Prof. Mordechai Shani, Director-General of the Israeli Ministry of Health. I would also like to thank the co-chairpersons of the working groups this afternoon.

An event like this required substantial planning and organization. I would like to thank the organizing team -- Dena Asfour, Tamara Barnea, Hussam Sharkawi, Bruce Rosen, Meira Aboulafia and Natalie Budwig. Please allow me to make a tiny personal comment. This year is the 40th anniversary of my first trip to Israel, and today's event is for me a great gift. It affirms my belief that the programs we help to create can be the true building blocks of peace.

Tamara Barnea: I would like to thank all the speakers for their warm words and encouraging messages. We will now move on to the professional part of this meeting. The chairperson of the morning session is Prof. Jack Habib.

Prof. Jack Habib, *Director of JDC-Israel and the JDC-Brookdale Institute*: Good morning everyone. I'd like to welcome Dr. Sneh and our Palestinian colleagues, Dr. Zanoun and our Israeli colleagues. Did I mix that up? Well, I can't distinguish between you anymore -- you're all just colleagues. I'd like to welcome you all very warmly and to welcome our friends from the international community who have joined with us today. I think that we may be in the process of redefining the meaning of heroism in this part of the world. We have heard about the courage it takes to rebuild and develop the Palestinian health system, and we are going to hear about the courage it takes to bring Israel through a major revolution and transformation of its health care system, overcoming powerful vested interests. I think both of our speakers deserve a great deal of credit for the heroic effort of trying to describe all of these changes in a very short period of time.

I would like to turn immediately to our first speaker, Dr. Rafiq Husseini, Director of the Palestinian Council of Health and Assistant Deputy-Minister of Health for the Palestinian Authority. Dr. Husseini's background and extensive experience have well prepared him for the positions that he holds today. He is a graduate of the American University of Beirut, has a Ph.D. in microbiology from Loughborough University, and conducted post-doctoral research at various universities in England. He then gained experience of health management as director of the Medical Aid Program, U.K. In addition, he worked as the director of a hospital laboratory in Jordan. He recently completed a Masters degree in health management and is one of the designers

of the health plan for the Palestinian people in the West Bank and Gaza that we're going to hear about today. Dr. Husseini was appointed Director of the Palestinian Council of Health in April 1994, and he has recently been appointed Assistant Deputy Minister of Health for the Palestinian Authority. The latter appointment, I understand, was just ratified this month (October 1994), and I'm sure you'll all join me in congratulating him and wishing him a lot of luck.

The Palestinian Health Plan: Visions, Dreams, Hopes, Nightmares

Dr. Rafiq Husseini

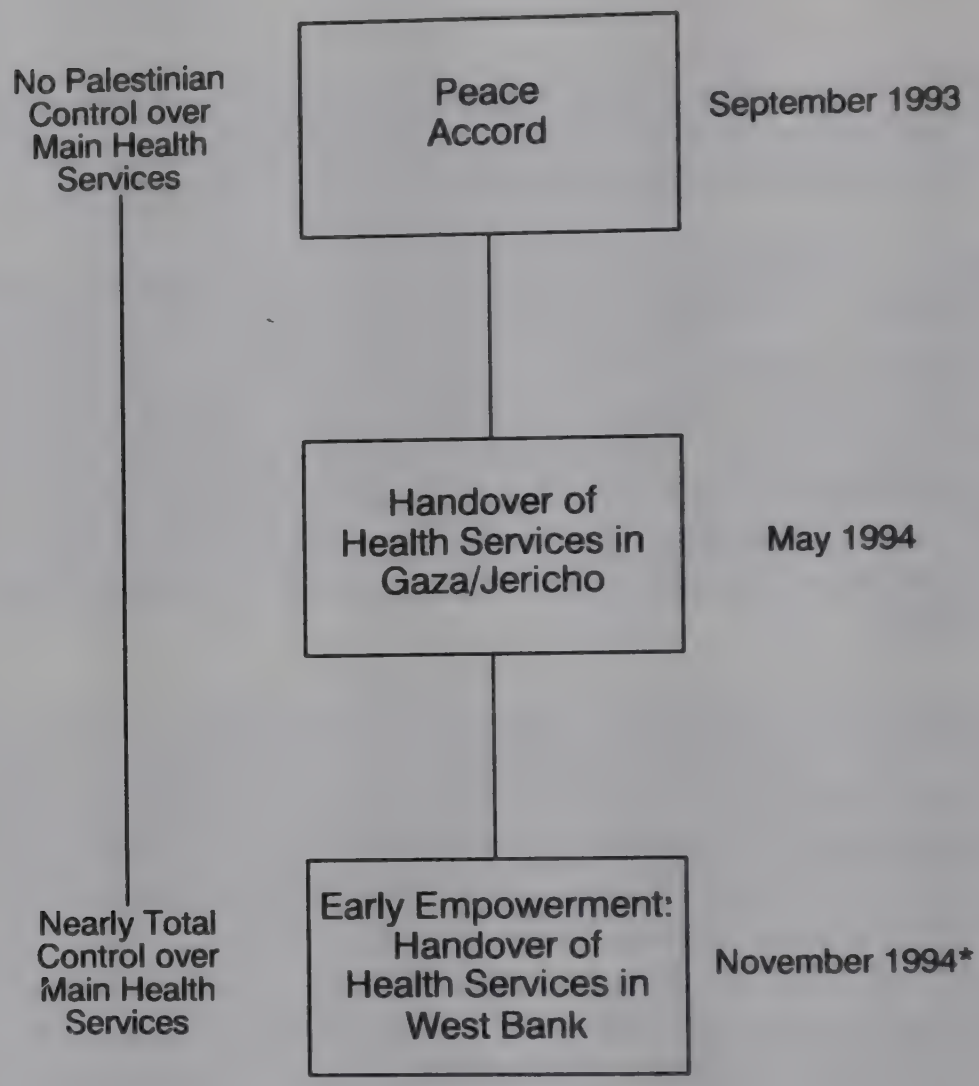
I'm going to try and describe the Palestinian National Health Plan to you. The title of my talk is 'Visions, Dreams, Hopes and Nightmares', because I'm afraid that nightmares will come before the dreams and the hopes.

Of course, I would first like to thank the AJJDC for organizing this meeting and for asking me to speak. It is a privilege to speak in front of such a crowd of professional people. Of course, I'm also very proud to say that the Health Plan is not my work. It is the work of literally hundreds of people, and it was started a long time ago. I'm just the one to tell you about it. My work has been quite negligible. It's only because hundreds of people have sat together in workshops and seminars, and talked about it and fought about it, that we have something we can call a plan. The plan is still in its infancy, but at least we're trying.

Let me describe to you what is happening on the political scene (Figure 1). You know that in September 1993 a peace accord was signed. In May 1994, there was the hand-over of the health services of Gaza and Jericho (which Dr. Zanoun has talked to you about), and we hope that next month there will be early empowerment and a hand-over of the West Bank health services. We don't know for sure. Perhaps it will happen in November, or in December, or in January -- and so on and so forth. We are assuming that as we have signed an agreement, there will be early empowerment and a hand-over of the West Bank health services. So basically we have moved from very little Palestinian control over health matters to nearly total control, and this in itself presents a very daunting task.

Let me describe how things have evolved with us (Figure 2). In 1968, the Palestinian National Council, our parliament in exile, entrusted the Palestine Red Crescent Society (PRCS) to take care of health services for the Palestinians. The PRCS functioned mainly abroad, because it was illegal to function in the occupied territories, but it was nevertheless considered to be the health authority -- the government in terms of health.

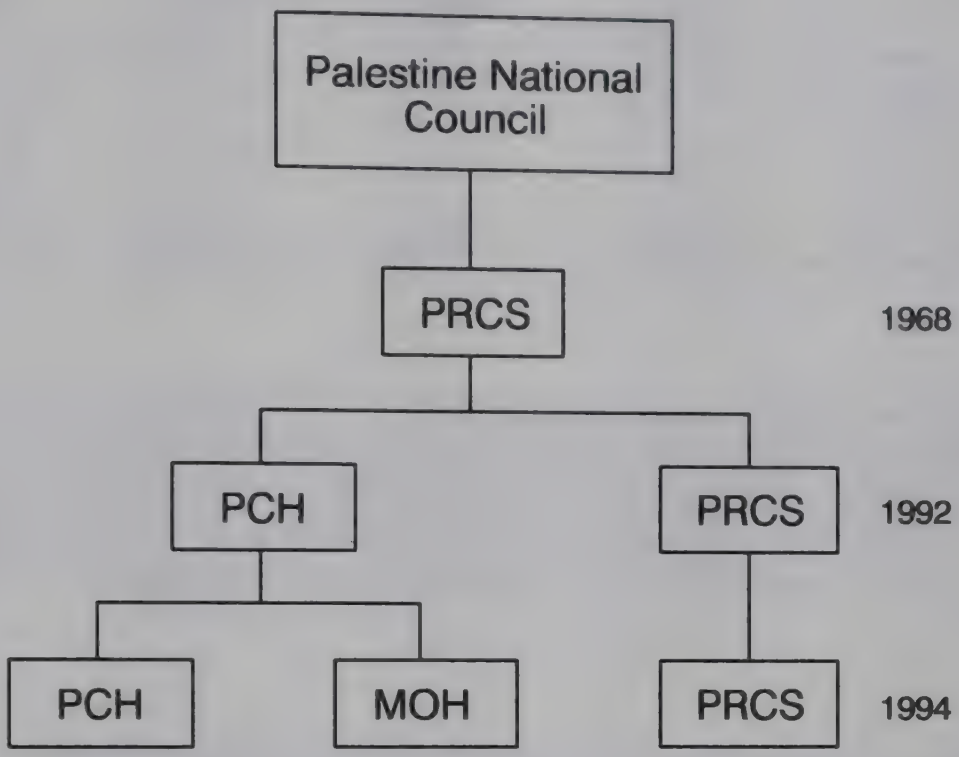
Figure 1: The Handover of Control over Health Services



* The Palestinian Authority assumed complete control in December 1994.

In 1992, the PRCS split in two according to its two functions: the ministerial or governmental function and the Red Cross function. Thus the Palestinian Council of Health (PCH) became the authority responsible for health services -- the government and policymaker, if you want. The PRCS, meanwhile, was moving towards becoming the local Red Cross society.

Figure 2: Evolution of the Palestinian Health Authority



In 1994, as you know, the PCH itself split in two, and there is now a Ministry of Health (MOH), of which Dr. Zanoun is the head. Before this, Dr. Zanoun was director of the PCH in Gaza, that is, my counterpart in Gaza. Of course, some of the people in the PCH will move to the Ministry of Health. Others will not, because the PCH has people from United Nations agencies and non-governmental bodies. It does not have just governmental people. It is a separate body, and we are presently trying to define the roles that each organization will play, given that the Ministry of Health is obviously the executive body and the body that will organize health care for the Palestinians in the West Bank and Gaza.

I'm sure you're all more knowledgeable than me about the figures involved, since both Israelis and Palestinians have worked with them over a long period of time. But let me just give you a brief outline of the facilities available (Table 1). First, there are a lot of clinics, that is, primary health care facilities. These are mostly curative clinics, however, and do not fit the definition of primary health care facilities that we all know. There are 206 government clinics in the West Bank and Gaza, 42 UNWRA clinics and 230 clinics run by non-governmental organizations (NGOs) -- in short, a large number of clinics.

Table 1: Number of Primary Health Care Facilities by Provider, 1994

	Government	UNRWA	NGOs	**Total**
West Bank	178	33	202	**413**
Gaza Strip	28	9	28	**65**
Total	**208**	**42**	**230**	**478**

Hospitals are another matter, because there are limited numbers of beds (Table 2). The governmental beds number nearly 1,740, there are 43 UNRWA beds, and an UNRWA hospital with an estimated 235 beds (at the last count) is now under construction in Gaza. In addition, the NGOs have nearly 1,000 beds, most of these in the West Bank, with half in East Jerusalem.

Table 2: Number of Secondary Health Care Facilities by Provider, 1994

	Government		UNRWA		NGOs	
	hospitals	beds	hospitals	beds	hospitals	beds
West Bank	9	974	1	43	10	942
Gaza Strip	5	766	NA	0	1	80
Total	**14**	**1740**	**1**	**43**	**11**	**1022**

Table 3 presents the figures for expenditure on health care for different providers in 1994, some of which are estimates and some of which are real. The Israeli Government spent about $65 million on health care, UNRWA nearly $25 million, and the NGO community an estimated $40 million. This means that the total expenditure of these three providers in 1994 was nearly $130 million.

Table 3: Expenditure of Health Care Providers (in millions of U.S.$)

	Government 1993	UNRWA 1992	NGOs 1991	**Total**
West Bank	45.2	12.0	NA	**57.2**
Gaza Strip	20.0	12.7	NA	**32.7**
Total	**65.2**	**24.7**	**39.0** (est.)	**128.9**

Let me try to describe the system in a simple fashion (Figure 3). Basically, there are a lot of providers and the system is uncoordinated, fragmented. It has mushroomed, rather than grown out of a plan. There is duplication and competition, some of which is political, some non-political.

Figure 3: The Palestinian Health System

- Uncoordinated, fragmented, mushroomed rather than planned
- Duplication and competition
- Large numbers of curative clinics
- Adequate numbers of doctors and nurses, but "incomplete" training
- Inadequate numbers of specialized staff
- Good vaccination coverage, perhaps over-coverage

Insured (compulsory and voluntary): 25% of the population
Life expectancy: < 65 years
Infant mortality: 30-50 per 1000
Beds/1000 0.5-1.3 (East Jerusalem > 3.5)
Per capita expenditure: US$65 (Gaza: $45; Israel: > $350)

We are not sure of the exact figure for life expectancy, but it is about 65 years. As for the infant mortality rate, there are figures that put it at less than 30 (per 1000), and figures that put it at about 100, but I will give a figure of 30 to 50. My colleagues will say it should be 41 when they look at the statistics, but we don't really know as yet. We don't know because, basically, what we have are reported infant mortality rates, not actual infant mortality

rates. There is a difference between these two figures, and it is our job to discover this difference so that we have a baseline to start from.

The beds per 1000 ratio is between 0.5 and 1.3. East Jerusalem has a very high ratio, at least 3.5, but areas such as Jenin, Tulkarem and Hebron have low ratios: 0.5, or in some areas even less.

Our annual per capita expenditure on health is about $65. This includes expenditure by NGOs, the Israeli Government and UNRWA. We don't have exact figures for how much is spent by the private sector, but some put this sum at $20 to $30 per capita.

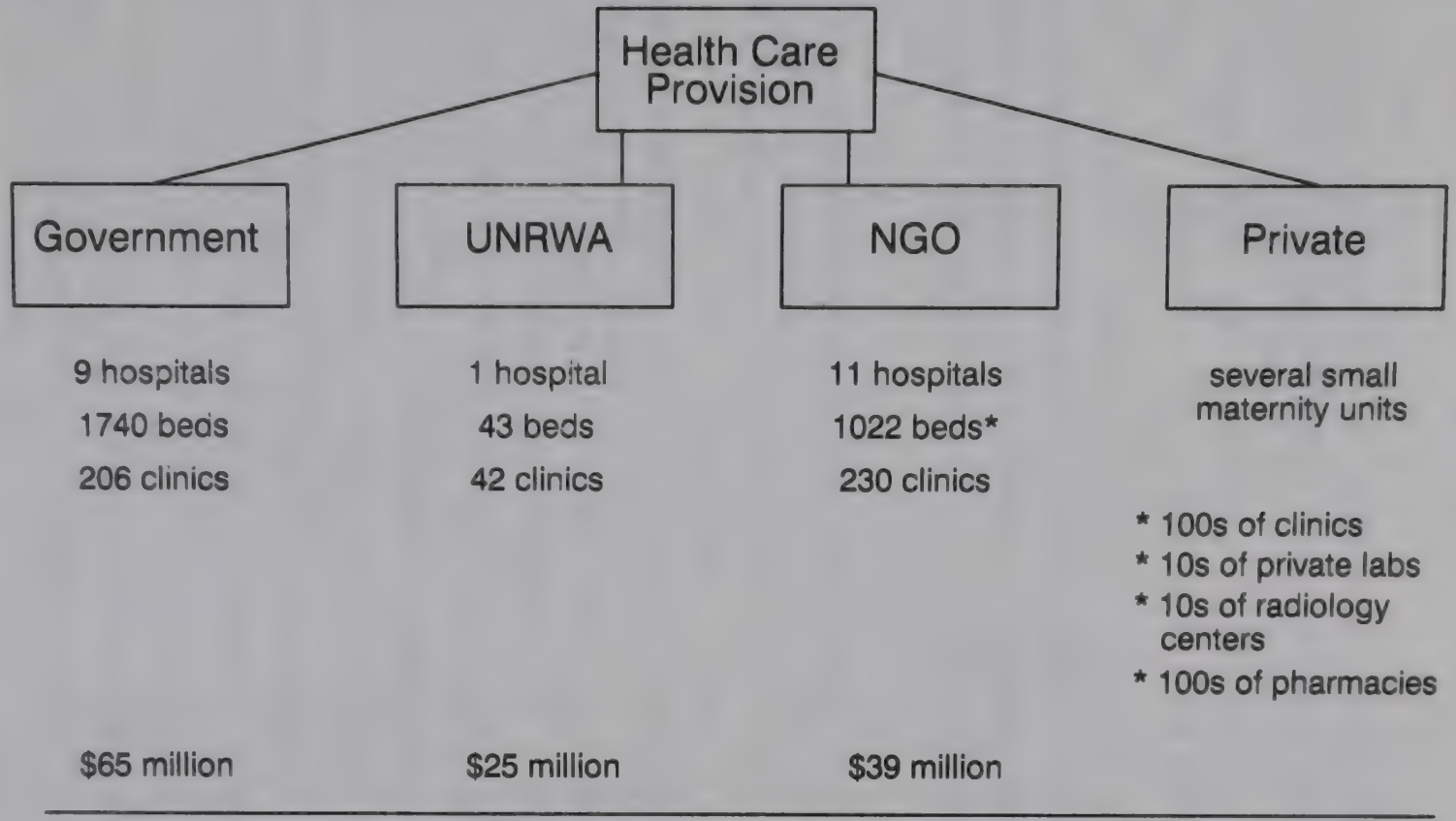
As I have said, there are large numbers of primary health care clinics, nearly 500 of them. The numbers of doctors and nurses are adequate, but we feel that some medical staff have had insufficient training. One reason for this is that our medical doctors have trained in 600 universities around the world. Some have trained in very good universities, such as Johns Hopkins or the Harvard Medical School, and some in poorer universities, such as Chita Kong in Bangladesh.

There are inadequate numbers of specialized staff among the nurses, doctors, and other health workers. Most of the medical staff, then, are general doctors and general nurses, and this is a problem we have to face and do something about. There is good vaccination coverage in the West Bank and Gaza, as you all know, and therefore no epidemics. That epidemics have occurred in Israel, rather than in the West Bank and Gaza, is something almost miraculous. Some people, of course, say that there is over-coverage -- take the example of polio, for which two vaccines are given, not one. There are a lot of arguments about this in the health field, and we ourselves will no doubt argue about this too.

Before the Palestinians took over in Gaza and Jericho, about 25% of the population had health insurance (compulsory or voluntary). In other words, 75% of the population are not insured.

As I have said, there are four sectors involved in health care provision: the NGO sector, the Israeli Government, UNRWA, and the private sector (Figure 4). Let me talk a bit about the private sector. While there is nothing properly developed in the private sector at the level of secondary health care, there are a lot of initiatives around at the moment to set up small maternity units. The private sector has hundreds of clinics, hundreds of pharmacies, tens of

Figure 4: Health Care Provision, 1994



* Including East Jerusalem (West Bank, and Gaza have only 517 beds)

laboratories, tens of radiology centers, but there is an unfair distribution of facilities.

I'm sorry if I'm going back to basics and trying to teach you what you teach your students, but it is important to bear these facts in mind whenever we look at the issues -- whenever we try to find solutions, try to fix our minds on what constitutes a successful health care system. No country has this system, of course, not even the U.S.A. with its vast resources. It is imaginary -- something to strive towards, the utopia we all want to achieve. Health services should be available, accessible, affordable, efficient -- and of course cost-effective and otherwise effective, and equitable: everybody should have the same access to health care, regardless of their means, the money that they have in their pockets. As Dr. Zanoun has pointed out, money is important. You can't do much without money.

Now let me talk about the development of the Palestinian National Health Plan (NHP) (Figure 5). We started discussing the health plan in 1988, during the Intifada. We knew about the health needs and medical needs in the West Bank and Gaza, and we started to plan what we on the outside could do, how we could help, what we could offer and how we could support the Palestinians living there. These were the original discussions. We made several attempts at planning -- some on the back of an envelope, others on the back of a stamp -- but we tried. We attempted to do something. And then an NHP commission was set up in Jerusalem. Hussam Sharkawi, who is with us today, was the director of the commission. It was chaired by Dr. Salim Husseini, who died recently. Many professional brains in the West Bank and Gaza joined this commission in an effort to produce a national health plan. The process took years. It took a lot of workshops and seminars to convince people of the need for a plan. In 1990, the idea that the Palestinians should have a national health plan was amazing to many people, who could not see the relevance of it. Why should the Palestinians want to waste time, effort and money in developing a national health plan, with territories under occupation and no hope in sight? I think the NHP commission has proved them wrong. In September, when the talks with Israel started, and the peace process gained momentum, people began looking for documentation of the what, how and where of the plan.

Figure 5: Development of the National Health Plan

1988	Initial discussions
1989	First attempts
1990	NHP commission set up
April 1994	Final draft of plan
April 1995	Scientific review

The final draft of the NHP was published in April, 1994. We're hoping that there will be a full scientific review of the plan in April, 1995. We believe that no matter what you do, you cannot have a plan that takes into account every eventuality. A health plan has to be dynamic, has to change, has to move with the times and follow new developments taking place in the health care field. In the NHP, we defined three basic elements that we wanted to discuss: disease prevention, health promotion and health protection (Figure 6).

I don't want to bore you with all this, but I think it is important that you see how we're thinking. For effective disease prevention, for example, we need to have competent and efficient management and support services. We need to continue with successful immunization and the control of infectious diseases. We need a good health information system, something we lack at present. We need adequate mother and child health care (MCH) services. We need to prevent coronary heart disease and other chronic disabling diseases. We need to diagnose cancer in its early stages and try to prevent cancer if we can. We need to increase primary health care provision and to involve the community in this. We need to control congenital diseases -- we have a problem with congenital diseases due to intermarriage, intra-family marriages, and so on. We need to improve quality of life and life expectancy. These are the goals we would like to achieve with this plan, the goals put forward in all the workshops. Developing the NHP has involved hundreds of people joining together to put forward policies, or at least guidelines, for the plan.

For effective health promotion, we need to promote physical fitness (I should start with myself, I guess). We need to eliminate malnutrition, reduce smoking -- because, as you know, we are a nation of smokers -- and reduce alcohol and drug abuse. The latter are not major problems, but they may become major problems in the future. We also need to remove politics from the issue of birth rates and family planning, and introduce family planning

Figure 6: Elements of the National Health Plan

I Disease Prevention	II Health Promotion	III Health Protection
Competent and efficient management and support services	Promote physical fitness	Reduce accidental injuries
Good immunization and control of infectious diseases	Eliminate malnutrition and under-nutrition	Establish efficient and effective emergency services
Effective health information system	Reduce smoking	Develop rehabilitation services
Adequate mother and child health services	Reduce alcohol and drug abuse	Develop public health laboratory services
Prevention of coronary heart disease and other chronic disabling diseases	Introduce culturally sensitive family planning	Ensure good oral health services
Early diagnosis and prevention of cancer	Promote mental health issues	Strengthen food and drug safety measures
Increase primary health care provision and involve community	Reduce violent and abusive behavior	Promote occupational safety and health
Control of genetic diseases	Promote health education	Protect from environmental health hazards
Improve quality of life and life expectancy for elderly	Institutionalize continuing education for health professionals	

programs. This is very important, as we have an extremely high birth rate. We need to promote mental health issues because, as Dr. Zanoun has pointed out, there are a lot of ex-prisoners, and I've yet to see somebody coming out of prison who is totally normal. Nelson Mandela is probably the only one to have come out of prison with his senses intact. I can assure you that most people don't emerge from prison totally normal. They need rehabilitation, as do their families. We also need to organize health education campaigns and institutionalize continuing education for health professionals, so that they can promote health education.

Health protection goals include the reduction of accidental injuries, the establishment of an effective emergency system, the development of rehabilitation services for the disabled, and the development of public health laboratory services to ensure good oral hygiene and health care, something that is lacking in the government sector in general. We also need to strengthen food and drug safety measures, and to promote occupational safety and health. Moreover, we need to ensure protection from environmental hazards, which, as Dr. Zanoun has said, know no borders.

I thought it appropriate to call the ten points of the NHP the Ten Commandments (Figure 7). We feel that these ten points should be our "commandments", the vision that will guide us in the coming few years. The first point, of course, is to concentrate on primary health care, so that primary health care forms the backbone of the system. However, there also has to be capital investment in secondary health care facilities, which are run down and in need of investment.

Of course, there have been a lot of debates about primary health care. My own feeling -- and I've said this on several occasions -- is that primary health care professionals should be better educated than secondary health care professionals. Actually, you start out as a secondary health care professional, and then you specialize in either primary health care or tertiary health care. A doctor working in a clinic on his own, with just a stethoscope to help him or her diagnose a patient's condition, needs far greater knowledge and information than a doctor in a secondary health care facility surrounded by laboratories and MRIs and CT scans. Working in primary health care is not an easy task. It requires a great deal of training and we have to concentrate on this training.

Figure 7: Vision for Health -- The Ten Commandments

1. Primary health care is the backbone of the system, but capital investment in secondary health care is also required
2. Rehabilitate the system with minimal disruption
3. Rehabilitation of the system has to be a joint effort of the Palestinian Authority, NGOs, UNRWA and the community
4. Quality of care should be stressed at all levels
5. The NGO and private sector will be supported and strengthened
6. Regulations and standards will govern all aspects of health care delivery
7. Commitment to an affordable health insurance through cost-effective services
8. Continuation of services for Palestinians abroad is a prime concern
9. Special attention should be given to women, children, ex-detainees, the disabled and the poor
10. Human resource development must be planned at national level

The second point is to "rehabilitate" the health care system with minimal disruption. We don't want to march in, sack half the staff, replace them with people from outside the system appointed on the basis of political or other merits, and see the system collapse suddenly in our hands. The rehabilitation should take place with minimal disruption and be a process that takes years, rather than weeks.

The third point is that the rehabilitation of the system has to be a joint effort, since there are several providers in addition to the Palestinian Authority -- especially in the West Bank. There is UNRWA, which is responsible for a great deal of the health care provision, and numerous NGOs, which are also very active. (There are about 55 major NGOs working in the field of health care in the West Bank.) Then, of course, there are the local communities, whose health needs may be very different from those of the health care professionals, the NGOs, the United Nations, and the Palestinian Authority. All these must be brought together in a joint effort to change the system.

The fourth point, an extremely important one, is to promote the quality of care. There is no point in having 500 clinics, if these clinics are not producing the effects they should produce. It is better to have 100 clinics that do their job efficiently, effectively, with an emphasis on quality rather than

quantity. From now on, we should try to concentrate on the quality of the health care provided.

The fifth point is to neither dismantle nor discourage the NGO sector and the private sector. On the contrary, we must support and strengthen them. Only a foolish government, a very foolish government, will take responsibility for providing all health services. This should not happen. A good government should manage the system, plan, coordinate -- it should not provide services if it can help it. The provision should be left to NGOs and to the private sector. This move from large systems to small systems that can be better and more easily managed is taking place in health care systems all over the world.

The sixth point concerns regulations and standards for governing all aspects of health care. In the West Bank and Gaza at present, we have minimal or, in some cases, no standards. These must be developed, since without standards we cannot license, we cannot accredit, we cannot have a sense of direction. Regulations and standards are essential to the NHP.

The seventh point is to have an affordable health insurance system covering the vast majority of the population. This is the only way we will be able to finance the health care system. Otherwise, we have a problem.

The eighth point concerns services for Palestinians living abroad. This is something that is close to my heart, as I've lived abroad almost all my life. The Palestinians living in Lebanon are suffering. I've been visiting them regularly, and they have a major problem: they are not eligible for health services provided by the Lebanese Government. They have access only to UNRWA services, which provide only primary health care, and which are being cut back. The economic situation of these Palestinians is very bad, and they cannot afford to pay for health services. We feel very strongly that they should be supported somehow.

The ninth point involves giving special attention to particularly vulnerable groups -- women, children, former detainees, the disabled, the poor.

The tenth point is that human resources development should be achieved within the framework of a national plan, not in a haphazard fashion, without sufficient thought and understanding.

In addition to the NHP, we have been drafting something called the *Interim Action Plan: Addressing Immediate Health Needs for Palestinians, 1 June 1994*

- *30 May, 1996*. In the few minutes left to me, let me briefly tell you about the objectives of the Interim Action Plan (Figure 8). First of all, we want to set up a national health authority capable of managing the health care system effectively and efficiently. Next, we want to ensure the continuity of health care provision, and to upgrade the level of health care services. Finally, we want to formulate a detailed five-year implementation plan based upon the NHP.

According to the latest estimates, we will have an income of $51 million over the coming two years, while our expenditure during this period will be $287 million (Table 4). Of course, income has been estimated very conservatively, whereas expenditure has been estimated realistically. It is very difficult to estimate the income from health insurance fees for the next two years. As Dr. Zanoun has said, if the 30,000 people working in Israel have their health insurance paid by the Israeli Government, this will greatly increase the health insurance fees coming from Israel. If the government does not pay for their health insurance, however, we will not receive this additional income. Of course, the estimate for expenditure includes both running costs and the cost of upgrading existing services. As Table 4 indicates, nearly $95 million will be spent over the two-year period on upgrading services -- primary health care services, secondary health care services, school health programs, etc.

Based upon these estimates, the deficit for the coming two years is $235 million. We are trying to raise this sum. We don't know where it will come from. If we don't succeed in raising it, we will have to cross out those items that are not essential.

Financing the system will be complicated, because there are government services, NGO services and UNRWA services, all of which have to be coordinated and harmonized, and complement each other (Figure 9). We hope to finance the system with local contributions, fees, fees for services, health insurance fees, together with the aid from foreign governments expected over the next five or six years, aid from international agencies, and of course taxation. Taxation is something of a sore point at the moment. We have been teaching the Palestinians, or rather compelling them, not to pay taxes to the Israelis. Now, as a result of peace and autonomy, we are saying that they have to pay taxes, and this will not go down very well with the Palestinians. An education program on why it is essential that we Palestinians pay taxes has to be implemented.

igure 8: The Interim Action Plan -- Addressing the Palestinians' Immediate Health Needs, 1 June, 1994 - 30 May, 1996

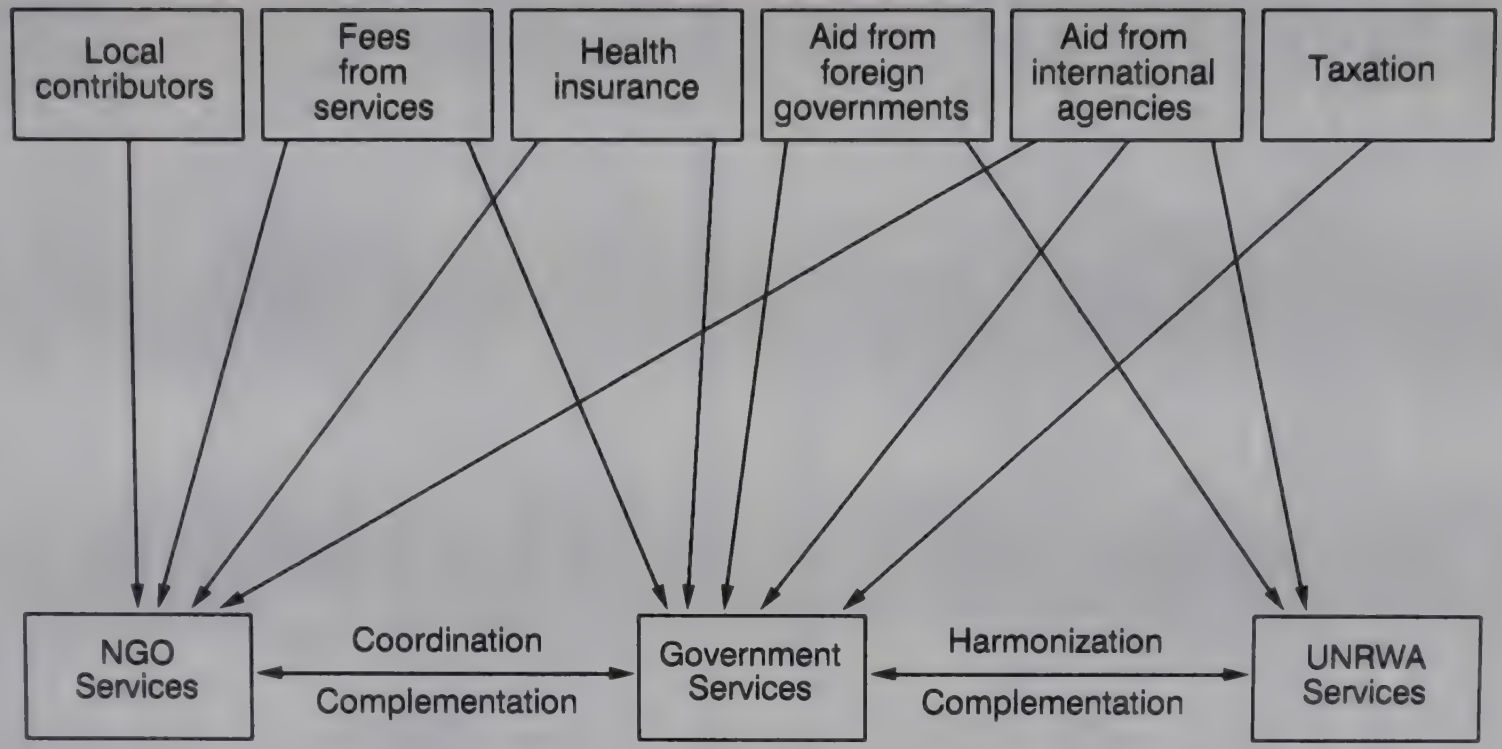
Goal	**To meet the immediate health needs of the Palestinians within the framework of the National Health Plan**
Objective I	*To develop a National Health Authority capable of managing the health sector effectively and efficiently* - to assess and plan for health needs - to set policy and establish standards - to coordinate health services - to monitor and evaluate service provision - to manage government health services
Objective II	*To ensure continuity of health care provision* - to ensure continuity of vital health services - to ensure continuity of UNRWA health services in close coordination with the Palestinian Health Authority - to enable vital local NGO and charitable services to continue activities in close coordination with the Palestinian Health Authority - to ensure the provision of basic health services to Palestinians abroad during the transition period
Objective III	*To upgrade the level of health care services* - to train and recruit personnel - to renovate existing facilities - to upgrade existing services - to introduce new vital services
Objective IV	To formulate a detailed five-year implementation plan based on the National Health Plan

Table 4: Overall Action Plan Budget (for 2 years) (in millions of US $)

Item	WB/Gaza[1]	Diaspora
INCOME		
Fee from services	6.50	2.00
Health insurance fees	13.60	NA
Income from agreed external funds	31.20	4.00
Total Expected Income	**51.30**	**6.00**
EXPENDITURE		
I.Develop a National Health Authority		
* institutional development of PHA	3.50	0.00
* health management information system	3.00	0.50
* survey of health human resources	0.30	0.04
* continuing education system/programs	2.00	0.50
* health services management unit	2.60	0.00
* essential national health research unit	1.00	0.00
Sub-Total	**12.40**	**1.04**
II.Ensure Continuity of Provision		
* government health services	148.00	18.00
* NGO fund	30.00	0.00
Sub-Total	**178.00**	**18.00**
III.Upgrade Level of Health Care		
* primary health care		
renovate/introduce vital services	8.00	1.90
school health programs	1.00	0.00
mental health programs	2.00	0.00
assessment of PHC programs	0.25	0.00
improvement of PHC programs	0.75	0.00
* secondary health care	65.30	3.30
* rehabilitation	5.00	1.00
* public health laboratory	4.00	0.00
* upgrading blood bank services	1.00	0.00
* priority health programs		
environmental health programs	3.00	0.00
emergency medical services	3.00	0.00
priority health programs (vacc., etc.)	2.00	0.50
Sub-Total	**95.80**	**6.70**
IV.Develop 5-Year Implementation Plan	1.00	NA
Total Expected Expenditure	**287.20**	**25.74**

[1] Figures for the West Bank are based on actual income from January 1 - August 39, 1994; those for Gaza are based on actual income from June 1 - August 30, 1994.

Figure 9: Financing the System



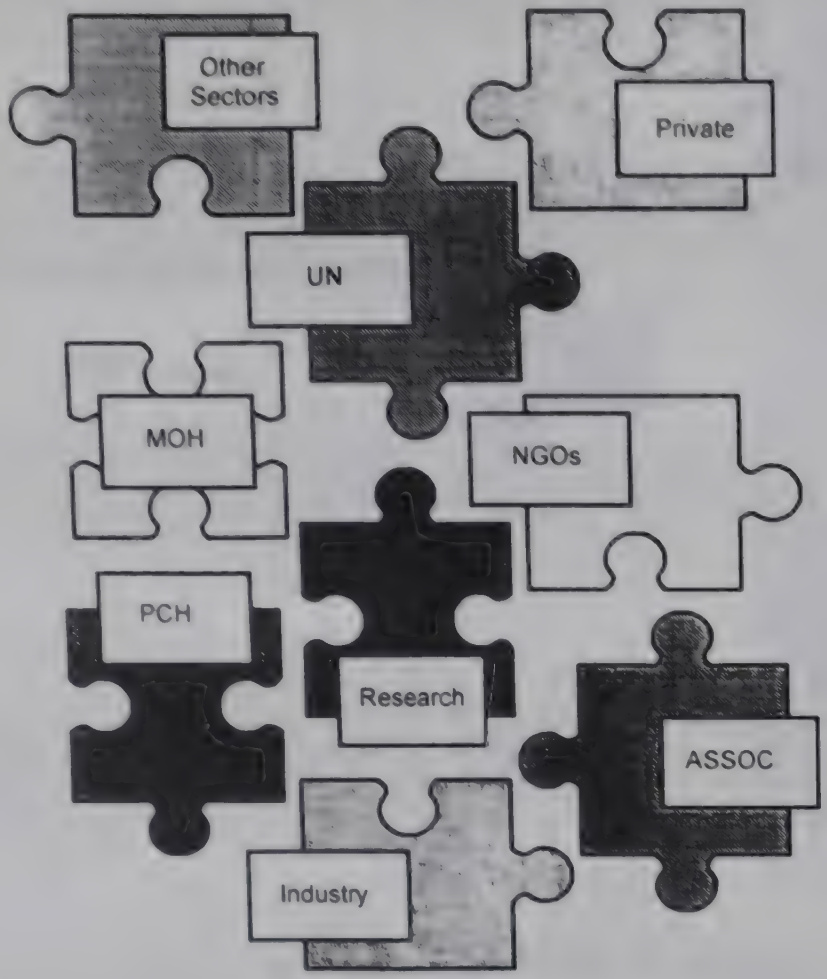
There are a number of tasks to be done at national level (Figure 10). At the moment, our services are not coordinated. A lot of people from different sectors are working in the area of health care, and it is vital that we bring them together, coordinate services and fit the pieces of the puzzle together (Figure 11). Of course, this won't be easy. Imagine having one or two pieces of the puzzle in your hand, and having to somehow assemble the other pieces: some of them seem to have little feet, because they keep trying to move away from you as you try to pull them towards you. It will take a lot of effort to fit the pieces into a whole. This is our situation at the moment -- we are trying to traverse a narrow ridge above a crocodile pit, and the crocodiles are waiting for anybody who falls down. The PCH looks as if it may fall into the pit at any moment, but don't you worry, it is actually firmly on the ridge. The Ministry of Health also looks rather unsteady. The crocodiles of bureaucracy and the status quo are in a strong position and will not move.

Figure 10: Tasks Needed at National Level

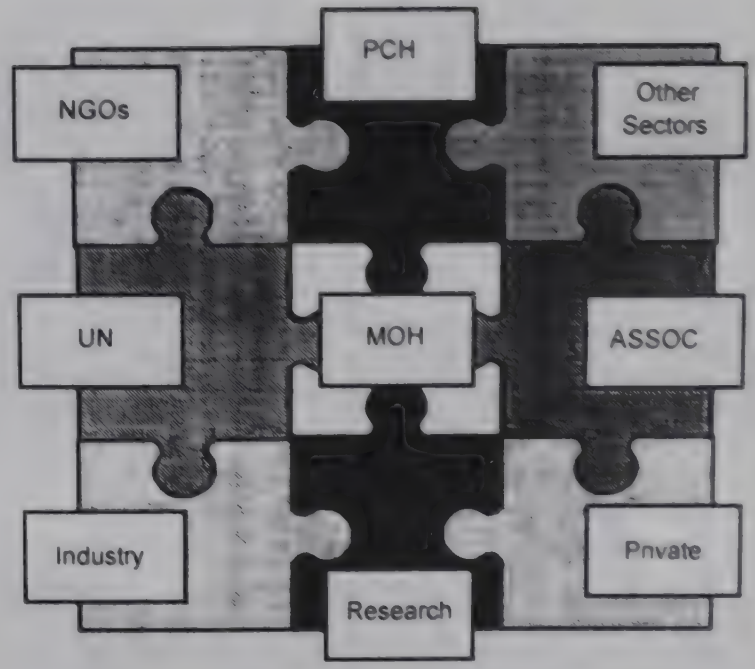
- Centralization of planning (with consultation, collaboration and communication)
- National policies, standards and regulations (with consultation, collaboration and communication)
- Licensing and accreditation
- Coordination and decentralization of health care provision
- Improvement in quality of care
- Monitoring of efficiency and cost-effectiveness
- Continuous evaluation and feedback

Of course, the big issue facing us is how to define our priorities (Figure 12). Hundreds of millions of dollars may soon be coming in, and priorities must be set. Health economists are now giving us economic evaluations and cost calculations, and saying that it may be more beneficial to the community to build a road rather than a hospital. Of course, there are political issues involved here, issues that can mobilize people. If a baby in England dies for lack of an incubator, then suddenly there is a rush to get incubators: the Minister of Health issues directives stating that incubators are essential, and hospitals purchase them. Health professionals have their own priorities. They all want MRIs, CT scans, elaborate and expensive equipment. We have to see

Figure 11: Existing Situation and Projected Situation of Health Care System



Existing Situation



Projected Situation

Figure 12: Competing Priorities

if we can afford these items, as well as meeting the needs of the community. We hope that we will come up with results that create a happy medium. This is what we are working towards.

Another issue that we feel very strongly about is the provision of technical assistance (Figure 13). As you know, millions if not billions of dollars have been pledged to the Palestinians, but almost all this money will come not in the form of cash or buildings but in the form of technical assistance. We will have consultants coming in to help us build our nation, most of whom have never actually built anything, only talked about it. This is something we feel very strongly about. These consultants are renowned academics with millions of publications to their names, but they have never run a health care system, let alone run a system that has succeeded. If they had, of course, they might have learned from their failures, built up experience. If we accept the money pledged to us, we will have no choice but to accept the assistance of thousands of technical people, because the money pledged is for technical assistance, not for anything else. If we don't accept the money, we won't have this flood of technical assistance. At present we are resisting accepting it. Of course, there are politicians who would like to see us accept it. If such and such government wants to give you money and technical assistance, they say, take it. We are saying that we would be overwhelmed if we took it all. If the assistance were not coordinated properly, it would not actually help us -- there would simply be a lot of documentation sitting on the shelves doing nothing (Figure 14).

I want to end my talk with a picture entitled "Don't give up!" (Figure 15). It shows a pelican trying to swallow a frog, who is strangling the pelican in order to resist being swallowed. I leave it up to you to decide where we are in this picture, although I can assure you that we're not the bird... We are either the frog, or -- if you can imagine it -- a fly in the frog's mouth. Thank you for listening. I hope that you've learned something from this talk -- I was certainly very happy to deliver it. I hope all the theory can be put into practice, and that we can move forward and build a health system equivalent to the Israeli system over the next few years.

Figure 13: Absorbing Technical Assistance

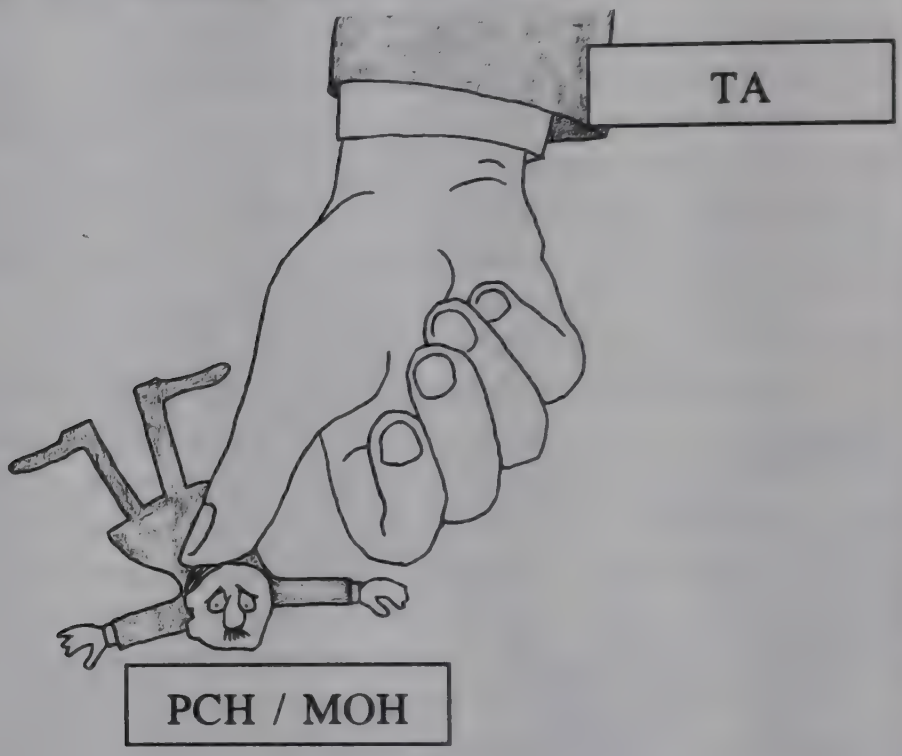


Figure 14: Dealing with International Agencies -- Possible Pitfalls

- Inadequate assessments of needs, resource availability and priorities
- Hasty design and implementation of projects
- Lack of real consultation with the Palestinian Health Authority
- IA follows own development assistance agenda
- IA refuses to fund maintenance of basic services
- IA recruits the relatively few trained and experienced staff away from public administration
- Aid concentrated in or around certain regions (towns)
- IA pushes creation of NGOs in which intentions are largely divorced from real needs
- "Neutrality" used as a pretext for not funding government services

Figure 15:Don't Ever Give Up!

The Palestinian National Health Plan: Discussion

Jack Habib: Listening to Dr. Husseini, I had two reflections. First, on an optimistic note, it took Moses a long while to sell the ten commandments to the Jewish people, but in the end he succeeded. Second, when you talked about health promotion objectives, I thought for a minute that you'd switched to needs in Israel, because we don't seem to have achieved all our objectives satisfactorily.

We now have a few minutes for questions. The floor is open.

Dr. Yitzhak Peterburg, *Executive Director, Central District, Kupat Holim Clalit*: First of all, I would like to thank Dr. Husseini for a wonderful presentation. I thought I knew about your system, but it was fascinating.

Now to my question. The first of your "ten commandments" said that primary health care should form "the backbone of the system", yet in the glimpse I had of your budget, $150 million were for governmental services, and about $60 million for secondary health care. In other words, about 70-80% of the budget is for areas other than primary health care. How do you explain this?

Rafiq Husseini: I included secondary health care in the first commandment because the existing system is very old and dilapidated. The buildings are so archaic the Ministry for Antiquities should get its hands on them. The problem is that we have to build a sound and effective system, with complementation of services. There is no point, in my opinion, in having good primary health care services if you don't have secondary health care facilities to refer patients to. The two have to go together. That's why there has to be an initial investment in capital, in renovation, in building, and in equipment. Of course, as we all know, primary health care is cheaper than secondary health care, so the fact that it hasn't been allocated a large budget does not mean that it is not important. It is very important, and we will continue to emphasize this. Most of the money for primary health care should go into the development of human resources -- primary health care physicians, nurses, etc. -- on which good primary health care depends. As I have said, though, there has to be initial investment in the structure of secondary health care.

Jack Habib: That's certainly an issue common to both systems. I'm sure we'll return to it in the afternoon.

Prof. Mordechai Shani, *Director-General of the Israeli Ministry of Health*: You presented a budget of $570 million for two years. I am including the deficit. Does the budget include all the resources available -- UNRWA and private money, as well as governmental?

Rafiq Husseini: Well, the budget doesn't include UNRWA or the NGOs, because it is really just to get the public health sector on its feet. However, there is a $30 million budget for NGOs, with which we would like to help NGOs continue to provide vital services to the community. I didn't understand how you calculated the five hundred and something million. This is a two-year budget. The whole sum is less than $300 million (about $287 million).

Mordechai Shani: Do you know the financial resources available to other agencies such as UNRWA?

Rafiq Husseini: UNRWA's annual budget is about $25 million. It may increase, but in 1992 UNRWA spent $25 million. As for the private sector, we don't know. The NGOs spend about $40 million annually. We don't know what their expenditure will be over the next two years. The budget is more or less governmental, apart from the NGO fund of $30 million over the two years.

Jack Habib: Could you teach us how to reduce our deficits that quickly? We need a solution...

Prof. Shmuel Pinchas, *Director-General of the Hadassah Medical Organization*: One reason for this meeting is to raise important questions. It would be presumptuous to make comments about the health plan as a whole, but I would like to bring up an issue which I was looking out for in your presentation but which you didn't mention: the issue of rationing. I wonder whether you didn't mention it on purpose. Obviously, you will have to ration services, and rationing leads to priorities, priorities to queues, and queues to a lot of things. There are two general approaches to rationing. One is to ignore the issue at higher levels, and to leave rationing to those in the field, to the doctors and nurses dealing with the patients. This doesn't work in new societies -- it has never worked in Israel. It works in the older democracies -- Norway, Denmark, and perhaps England -- nowhere else. The other approach is to establish a mechanism for setting a clear national policy on rationing and priorities and queues. According to your presentation, your national health plan totally ignores the issue of rationing. I'm not interested in *what* you will ration -- I'm sure you know that far better than we do. I'm

interested in the *mechanism* for rationing you intend to use. Are you going to ration services through brute administrative force, as some people have tried, and which is rarely successful? Or will the Palestinian Health Authority ration services through some form of consensus? Or will you use other means?

Rafiq Husseini: As you all know, rationing is a difficult issue. As you rightly said, in England they ration through the doctors and nurses, who apply their clinical judgement and delay or even deny treatment in cases where it will not be beneficial. They have been doing this for years. Thus it is the clinician who actually rations, creates queues and so on. Of course, we can also take the example of the state of Oregon, which tried to ration health services at the state level. There were three or four attempts at this, with officials attempting to discover what the public wanted. The public would come up with things that the government didn't want, and the criteria for rationing were not really morally acceptable, proving once again that the issue of rationing is very difficult indeed. I don't know how the Palestinians will ration health services. I think the best way to ration public health services would be to offer only those basic services considered essential for the community and not offer expensive services of low value. This is a very tough issue. It is particularly difficulty to ration services when your community is not highly educated or sophisticated. In such a situation, you need to understand people's mentality and to work with them, if you are to involve them in the rationing policy. Difficulties also arise when you have a professional community that is into high-tech medicine, and wants to push technology to its limit. This is a serious issue that needs to be thought about seriously. I do not know how we are going to deal with it. One thing I know is that we should set ourselves targets, and establish the services that we'll offer under the national health insurance scheme. If we don't do this, we may end up not providing these services. Actually, this may be the best way to go about it: after all, if you don't provide a service, then nobody asks for it, whereas if you do provide it, then everybody wants it, and you then have queues, lengthy queues. To tackle the issue of rationing logically, we must take into account the experiences of those who have failed in attempts to ration services. Of course, just because we try doesn't mean we will succeed.

Prof. Gur Ofer, *The Hebrew University*: Dr. Husseini, I heard you mention the word "taxation" at the end of your presentation. Is there serious provision in the national health plan for financing by the population, that is, through a health insurance scheme?

Rafiq Husseini: We have a special unit in the Palestinian Council of Health and the Health Ministry working on the issue of health insurance and on a health insurance scheme. We will try our best to finance the health care system through a health insurance scheme together with fees for services and so on if we can, but taxation will have to come into it. This will be a difficult task, because it is not only us and the health sector that are involved. The Ministry of Finance is also involved. There will have to be a good taxation system, with an effective tax collection system. This is a big issue that needs a lot of work. There is a limit to what we in the health sector can do on our own. We cannot go too far. I always say that we're attached to the rest of our community with an elastic band: we can go only so far before being pulled back in, and sometimes we can't go forward. The issue of taxation is particularly difficult. Palestinians have no experience of taxation. They now have to develop this. There has been a lot of talk between the Israelis and the Palestinians about taxes and a taxation system and so on. In the end, we will somehow have to depend on a taxation system. If we can set the system up internally, then we'll do it. If we can be self-sufficient and self-financing, that will be the best way forward.

Jack Habib: You'll have time to discuss the many other questions raised by Dr. Husseini in the working groups. I want to thank Dr. Husseini for his remarkable presentation of a great deal of information. Not only were we able to see the trees, but we got a view of the forest as well, which is particularly hard to do in a short amount of time.

We're now going to turn to our next speaker. I would just like to note that we've been joined by Mr. Leon Levy, a member of the board of the AJJDC and Co-Chairperson of our International Development Program. He has been a major champion of the AJJDC assuming a greater role in nonsectarian programs throughout the world.

Our next speaker, Prof. Mordechai Shani, is a graduate of the Hadassah Medical School, Jerusalem. He is a Professor of Internal Medicine and a Professor of Health Systems Management at the Tel Aviv Medical School and the Haim Sheba Medical Center, Tel HaShomer. He was Director of the Haim Sheba Medical Center from 1971 to 1992, except for the year 1979 when he served as Director-General of the Ministry of Health. Prof. Shani is one of the architects of Israel's recent health care reform. He was a member of the Netanyahu Commission, the State Commission of Inquiry into the Efficiency and Functioning of the Israeli Health Care System. In 1992, he returned to the Ministry of Health as Director-General, and has been a central

figure in the implementation of the reform. In 1970, Prof. Shani received the Albert Schweitzer Award for humanitarian work in the Gaza Strip and the Sinai Peninsula.

The Israeli Health Care Reform

Prof. Mordechai Shani

Good day. Having heard Dr. Husseini's excellent speech, I would like to slightly alter my presentation of the major aspects of our health care reform, to show parallels or dissimilarities between our concept of a health care system and the Palestinian concept.

I was delighted to hear that a master plan has been developed, because you cannot change or establish a health care system if you don't have the whole picture and, unfortunately, most of the countries in the world don't have such a master plan. This was, and is, one of the major problems of the American health care system, where each change deals only with a minor aspect of the system, and not the system as a whole.

It is recognized in the literature -- I think Rashi Fine was the first to mention this -- that there can be no revolution in health care without a social revolution, since health care policy is a manifestation of social policy. Yet we must qualify this concept by stating that if one moves from dictatorship to democracy, no revolution will occur in health services. After all, the last few years have seen a social revolution in Eastern Europe, with a move from dictatorship to democracy, and yet there has been no health care reform. I agree with Dr. Husseini that the large number of technical assistants who come as advisors tend to speak in general terms. When you try to initiate gradual reform, moving slowly from one step to another, you are often faced with confusion, and it is very hard to implement long-term reform.

When we analyze the reforms that have taken place in various countries, we find that most are not actually reforms. Rather, they are stages in the long history of the development of health care. Only a few countries in the world are really trying to implement reforms.

As you know, we can divide existing health care systems into three types -- health insurance, public welfare, and socialist.

In the West, there has been a gradual move from the public welfare type of system to the health insurance type, and the former Communist countries are also abandoning their old systems and adopting a health insurance type system. There are two basic models of health insurance. One is the Bismarkian model of sick funds, which we have in Israel, and the other is the Beveridgean model

of a national health service, which exists in the West Bank and Gaza. The pendulum has shifted over the years from one model to the other. For example, towards the end of the 1970s Italy, and later Spain, moved form the Bismarkian model to the Beveridgean model. Now the tendency is to transfer some aspects of the Bismarkian model to the Beveridgean model. However, I don't think that it's logical to establish sick funds in the West Bank and Gaza. I agree with Dr. Husseini that assigning the provision of health services to private, non-governmental institutions is a better approach.

One thing that Israel and the Palestinian Authority have in common is that we are both moving towards a revolution in the financing of health care. In fact, this is the principal reform in Israel. Until now, insurance premiums were given directly to the sick funds and not to a central agency. Next year, however, from January 1, almost all of the public money will go to a central body -- the National Insurance Institute -- which will be responsible for the allocation of that money to the individual sick funds on the basis of a capitation formula.

We have two problems with capitation. First, the data that we have are out of date. For example, the data we have on hospitalization are from 1987. In a few months' time we hope to have the data from 1990. However, we have no more up-to-date data. Second, the capitation involves allocation of funding only according to age, since we don't have sufficiently good data on other risk factors. The same situation exists in other countries, since a better formula is unfortunately not available.

In Israel, as a result of the health care reform, funding for health care is now channeled into a single pool. This has created two major problems. First, prior to the reform, premiums were paid directly to the various sick funds, and nobody dreamt what a vast amount of money was being spent on health care. Our policy makers later calculated that we were allocating NIS 15 billion of public money for health care. In the future, public health care institutions in Israel will have to fight over priorities with other governmental institutions unrelated to health because, like elsewhere in the world, health care is a great drain on resources. I agree with Prof. Pinchas that questions about rationing will certainly arise in future.

The second problem concerns the cost of hospitalization, with nearly half of the NIS 15 billion health care budget -- NIS seven billion -- going to hospitals. The issue of hospitalization costs in Israel is of particular concern to officials in Kupat Holim Clalit (Israel's largest sick fund), as 57% of their total budget

is allocated for hospitalization costs, and this percentage will only increase. This has implications for the health care system in coming years. We now allocate just 43% of our budget for primary health care and community care. With hospitalization costs set to increase in the near future, we may end up with a lower percentage of our budget allocated for primary health and community care, hindering the competition between sick funds which we would like to introduce into the health care system.

I don't believe that rationing will immediately become an issue in our hospitals. We have decided to cap a two percent increase (in real terms) in the funding allocated to hospitals, but I wouldn't call this rationing. If one analyzes what has occurred in Canada and Australia, both relatively modern democracies, one sees that capping the global budget has been a success in both countries. In Israel, however, hospitals are used to a situation in which prices are linked to inflation. It is our intention to hold discussions on the cost of secondary health care services with each hospital in Israel. The first one will be the Hadassah Medical Center in Jerusalem, and the second will be the Sheba Medical Center in Tel Aviv. These discussions will focus on the funding of each sick fund, and on the prices of hospital services. My feeling is that by reducing prices, either by governmental decree or by negotiation, we will be able to cap any increase in funding to hospitals without introducing rationing. I believe that the issue of rationing will arise -- as it has in Czechoslovakia, Hungary, and Poland -- as a result of pressure to introduce the latest medical technology. The cost of sophisticated technology places a very heavy financial burden on the health care system, and makes rationing unavoidable.

As I have tried to convey, the first aspect of Israel's health care reform is a redistribution of resources. The second aspect is the separation of health care provision from the government. What we have been working towards over the last five years is the transformation of hospitals into self-financing, non-profit entities, independent of the government.

The third aspect of the reform has already been touched upon by Dr. Husseini and concerns the role of the government (i.e., the Ministry of Health). Instead of being responsible for the day-to-day operation of hospitals, the Ministry of Health will focus on policy-making, planning, and the setting of standards. We feel that Kupat Holim Clalit should adopt a similar role, and relinquish its authority over the running of hospitals. It should compete with the other sick funds in providing community-based health care rather than hospital services. Discussing how to turn hospitals into independent entities, the recent reforms

in Britain come to mind. However, it isn't enough to simply start referring to hospitals as "trusts". Changing the name of an institution won't change the way it operates. One has to change the attitude of the management, establish a comprehensive database, and change the accounting system. This is a very gradual process.

Furthermore, when you try to appoint directors for these institutions, you realize the candidates understand nothing about the health care system, even if they are the top economic leaders in the country. You have to educate your management, educate your directors. You have to establish a database. It's a process that takes five to ten years. We are in the midst of this process in our general hospitals.

We believe that seven of the 11 governmental acute-care hospitals are ready for independence. The other four will require a much slower process, and will become independent only two to four year from now. Psychiatric and geriatric institutions will also become independent entities. We estimate that it will take about five to six years to change the way these institutions operate. In addition, under the new system, funding for psychiatric and geriatric institutions will come from the sick funds, so that the reimbursement mechanism will be between the individual sick fund and the institution. It will be very difficult for the psychiatric and geriatric institutions, particularly those operated by the government prior to the reform, to suddenly not receive a budget. They will have to "earn" their budget by selling services to the community. It will be a slow learning process, involving the education of institution directors and heads of departments regarding budgetary responsibility, for which a database is essential.

As I have mentioned, the third aspect of the health care reform is the reorganization of the Ministry of Health. From the founding of the State of Israel in 1948, the Ministry of Health has been principally concerned with the provision of health services. Prior to the reform, approximately 50% of acute-care hospitals and psychiatric institutions and 25% of geriatric hospitals were governmental, so that the Ministry of Health has geared itself to health care provision. By making hospitals and institutions independent of government control, the Ministry will be able to focus on establishing standards and policy. You may feel that there is a contradiction here: on one hand, we are telling the providers that they are independent, but on the other hand, we are moving towards centralization. This is because independence lies in the daily running of the institution, and not in policy-making, which will be centralized in the Ministry. Institutions will not be able to purchase specific items of equipment

or establish new departments as they please. The Ministry of Health will establish standards and criteria regarding budget allocation, thus playing a major role in the overall operation of health care institutions in Israel.

The reorganization of the Ministry of Health will involve establishing several new departments. The first of these will deal with standards for health care provision. At present, there is a lack of clear standards for service provision, and you cannot have national regulation of quality without first defining standards of care. The second new department will deal with technology and quality of care. The interrelationship of these two areas is extremely important, as I'm sure our colleagues in the Palestinian Authority are aware. At present, because of developments prior to the recent reform, we have 18 departments for in-vitro fertilization. Don't have that many! Try to establish no more than two such departments. Since implementation of the reform, we have been able to halt the purchase of more MRI (magnetic resonance imaging) machines. While our criteria are not generally based on political decisions, the Knesset recently decided, based on our recommendation, that Israel should not have more than one MRI machine per 750,000 people. At present, we have six. We need a seventh machine in the north of Israel, and these seven will be adequate for the Israeli population, at least for the next two years. This is in keeping with the criteria in Canada, rather than the criteria in the United States, where there is one MRI machine per 100,000 people.

We have clearly defined criteria not only for the amount of equipment allowed, but also for the number of departments. For example, we recently decided that children with congenital heart disease will be able to undergo operations in only six institutions, and we may well reduce this number to four. By concentrating specialties in a small number of centers, we can improve the quality of care. The Palestinian Authority is starting out with one center for open-heart surgery: you will need two such centers -- maximum three -- no more. Don't permit others to open, because it is only by building up expertise in selected centers that you will ensure quality of care. I believe you are correct in your assessment that there is a need for specialization in the Palestinian health care system. You will have to decide centrally which hospitals will be permitted to develop a given specialty, and ensure that others are not permitted to develop it.

Well, I'm sure we could talk about quality of care all day. However, it is very hard to apply criteria for quality of care. First, there is a need for data, and we lack data. In fact, the two main difficulties with our reform are the need for legislation and the need for data. As yet, we have insufficient data

to analyze the scope of health care available. In an effort to collect data on quality of care, it was decided that every institution should report any unexpected deaths among patients. This has not only produced data on risk factors, but has emphasized the need for risk management. Some of our hospitals -- those operated by Kupat Holim Clalit -- have very good risk management systems, whereas others -- governmental hospitals -- have no such system. The latter will have to introduce risk management systems, not only because the premiums for malpractice insurance are increasing steadily (neurosurgeons are now required to pay an annual premium of $8,000 each), but because we would like to improve the quality of care. In addition, we are planning to introduce performance indicators in the near future.

We encountered various problems when trying to reform the Ministry of Health, one being the huge range of medical specialties covered by the Ministry. The many specialists working in the different fields do not wish to neglect their private practices, their university posts, their research, by coming to work for the Ministry. For this reason, we are trying something that I believe to be an Israeli innovation -- the establishment of a national council for each specialty. Each council is composed of approximately 20-24 experts in a given specialty. For example, the council on oncology comprises several oncologists (including one from a small hospital, so that we don't deal only with main centers), as well as surgeons, primary care physicians, public health officials, a nurse, a psychologist, and physicians working in sub-specialties of oncology (bone-marrow transplantation, hemato-oncology, gynecology, etc.).

The purpose of these councils is to help the Ministry decide upon priorities and promote quality of care. For example, the council on cardiovascular diseases is currently discussing the number of catheterization labs needed in Israel. Should we have a catheterization lab in every hospital with a coronary care unit of at least six beds? Should the number of catheterizations be restricted? At present, 20,000 catheterizations are performed in Israel each year, and 5,000 PTCAs (percutaneous transluminal coronary angioplasties). Only the United States performs a similar number of catheterizations per capita.

These specialty councils will help us with decisions regarding technology, with the implementation of clinical guidelines drawn up by the Ministry and with other aspects of quality of care. We have a council on oncology, a council on cardiovascular diseases, a council on imaging, a council on trauma. The council on trauma is principally concerned with the large number of traffic accidents in Israel, but in the future it will also consider trauma in the home.

The council on surgery has numerous subdivisions, relating to specialties such as orthopedics, neurosurgery, etc. The council on psychiatry currently deals mainly with the legal aspects of psychiatry and the regulations governing psychiatrists. There is also a council on fertility, genetics and obstetrics, since we consider these specialties to be related. We hope to set up a council on rehabilitation and aging in the near future.

In addition to the specialty councils, we have also established a mini-version of the American Centers for Disease Control (CDC). Our intention is not to imitate the CDC, but rather to create a small center that will deal with infectious diseases, oncology, cardiology, and work-related diseases. We have allocated approximately $1.5 million to the center for establishing a database system because, as I mentioned earlier, we lack necessary data in many fields.

Another area that needs to be developed is human resources. To begin with, we have too many physicians. This is unavoidable because, being a country of immigrants, Israel has to absorb everyone arriving in the country, including physicians. Our problem is the opposite of that of the Palestinian Authority: we have too many specialists. One of the most important tasks we face is to negotiate with the Israeli Medical Association to try to limit the number of residency places for specialists, and to increase the number of residents going into family medicine, as a number of countries have done (e.g. the United States and Germany). In order to achieve this, however, we need an accurate and detailed register. At present, we don't know the number of physicians in Israel because we don't have follow-up. If I'd registered as a physician twenty years ago, and subsequently left my profession, I'd still be registered in the Ministry of Health.

In addition, we are trying to alter existing legislation, and introduce new legislation, regarding different health care professions. For example, we need new legislation for the nursing profession in Israel. As the Supreme Court noted recently, the existing legislation is based upon an old British law which is no longer relevant. The new legislation governing physicians requires physicians to renew their medical licenses every three years, and to supply the Ministry of Health with data on their professional experience over the previous three years. These data will keep us informed of developments in the various professions.

We hope to set up a database good enough to enable us to establish a dialogue between the universities and the Ministry of Health. If current trends continue, within ten to fifteen years there will be an even greater emphasis

upon specialization in hospitals, with nurses assuming responsibility for some of the aspects of day-to-day medical care. For this reason, we need to establish a continuing dialogue between the Ministry and academic institutions, so that syllabuses can be altered in accordance with current and projected trends.

The Ministry has already begun to influence university programs. For example, we have convinced Tel Aviv University to incorporate economics and aspects of quality of care into its medical school program. We would also like to promote the teaching of medical ethics in medical schools, by having this subject taught in the sixth rather than the first year. Only by carefully monitoring the teaching syllabuses for the health care professions can we determine whether or not changes need to be made. Primary health care is an area in which major changes are needed. We do not have enough family physicians, and the ones that we have are not true "gatekeepers". Proposals for a general practitioner fundholding scheme similar to that introduced in Britain were presented to the Netanyahu Commission, but these have not been implemented.

Furthermore, the competition between sick funds has not helped the situation. Even Kupat Holim Clalit, which employs family physicians, has sometimes permitted patients to apply directly to specialists. Thus, the trend in Israel has gone against the worldwide trend to introduce gatekeepers. One of the reforms we have to implement is the introduction of more family physicians and the establishment of a gatekeeping mechanism. I believe that the sick funds in Israel will be more receptive to this idea now that funding is from a central source. Prior to the reform, funding was allocated to the sick funds in the form of premiums received from members, and the richer sick funds thus received larger budgets.

These are the reforms we are trying to implement in Israel. With the enactment of the National Health Insurance Law, there will be no discrimination against weaker population groups. Every patient can now be admitted to any sick fund, no matter what his or her age or level of disability.

The transformation of the Ministry of Health will be a very lengthy process. It will take at least four to five years to establish a strong Ministry capable of establishing policy.

Hospitals will be transformed into independent trusts. Efforts will be made to improve primary health care through education and by changing the ways in

which family practitioners work. These are major reforms, and it will take us several years to implement them. It seems to me that there are similarities in our respective situations, even though we have different starting points, and I look forward to fruitful cooperation.

The Israeli Health Care Reform: Discussion

Jack Habib: Thank you very much Prof. Shani. In the spirit of that address, I wish, Dr. Husseini, that you could learn from our mistakes and avoid them, instead of having to reform your system after a number of years, but I'm afraid you'll find health care reforms unavoidable.

We'll take questions now. Perhaps some of our Palestinian colleagues would like to begin.

Dr. Abdel Jabbar Al Tibbi, *Director of Primary Health Care, Palestinian Ministry of Health*: I would like to ask about the national councils for each specialty. Can you elaborate on the national councils and their decisions? Does the Ministry of Health have to implement these decisions, or are they just recommendations?

Mordechai Shani: The decisions are just recommendations, for two reasons. First, every council member sees only his own field and you cannot accept every individual recommendation. Second, you have to set priorities. I promised most of the councils that if I or the Ministry don't accept at least 80% of their recommendations, it will mean there is no value to what they are doing and they will have to resign. Initially, it is very hard to teach clinicians from any field to think properly. A year ago we consulted with fifty experts -- in cardiology, internal medicine, lipids, hypertension and diabetes -- and each of them wanted a separate "council" for himself and to be able to talk directly to me. Of course, I could devote all of the resources in Israel to cardiovascular diseases alone. They did not see that only if they sat together on one council could we get a better, more comprehensive picture of what was needed in each field. We had to explain to them that their recommendations would be brought before the mini-CDC, and that, together, we would set priorities; if we don't accept any one of a council's recommendations, we explain why.

Representatives from the Department of Technology and Quality in the Ministry attend every council meeting. Up until two months ago, I also sat in on all meetings. Unfortunately, various problems preclude me from doing so at present, but I intend to do so again in the future, to encourage dialogue, to teach council members to think globally. It is also very important that all of the council directors meet, and go abroad to learn. For example, Prof. Robinson, the head of oncology at Rambam Hospital in Haifa and chairperson

of the council on oncology, spent four months abroad on sabbatical; he learned a lot and changed many of his ideas through talking with colleagues.

We have another problem that I don't think exists yet for the Palestinians. Until recently, the Israeli Medical Association insisted that every physician could perform any task. Suddenly we are coming to physicians and saying: "Stop. Even though you are a licensed cardiovascular surgeon, don't operate on children, because we want to limit the number of institutions in which children can undergo operations. Even though you are an orthopedic surgeon, don't operate on cases with a primary malignancy in the bones, because we want there to be only two centers for oncology in Israel". In fact, we have a particular problem regarding oncology. There are more than five hundred new cases of malignancy among children every year. Four hundred of these are treated in four medical centers, and one hundred are treated in six hospitals. We would like to close the "small shops", and concentrate treatment in a few large centers. This immediately arouses the antagonism of the Medical Association, so there must be a dialogue between the council on oncology and the Medical Association. We are having to teach clinicians to see all aspects of their profession.

Also, as I said earlier, we are trying to get people from different disciplines and categories in each field to serve on the respective councils. For example, the council on cardiovascular surgery comprises experts in internal medicine, cardiology, pediatric cardiology, lipids, hypertension, diabetes, nursing, primary care and epidemiology. Only by getting the perspectives of professionals in all sub-specialties in a given medical field can you make the best decisions -- and this is not easy. For example, do we want to recommend that diabetics get four injections of regular insulin per day, thereby allocating a lot of our resources to diabetes? Or do we want to prescribe more medications to lower patients' lipid counts? Our recent decision to change existing criteria and prescribe Texol for women with breast cancer, as well as for those with ovarian cancer, will necessitate the allocation of an additional $30 million every time this drug is included in a treatment track. This is an exceptional example, but it illustrates that a clear principle is needed concerning policy priorities, because even in Israel resources are limited.

Prof. Becky Bergman, *Department of Nursing, Tel Aviv University*: What are the plans for support and continuation of research and staff development within the health services?

Mordechai Shani: There will be no change. We shall continue to provide resources for education and research. There will be no reduction of resources in these areas. I would note that Prof. Bergman was the first nurse to serve on our oncology council until she decided to resign.

Hossam Sharkawi, *Coordinator of the International Cooperation Unit, Palestinian Council of Health*: When you spoke of the national council, I understood that you were speaking of the sub-councils organized by specialty. I remember that one of the Netanyahu Commission's recommendations concerned a macro-level national council. As I recall, this would attempt to involve a broader spectrum of the population -- both professionals and the general public -- in policy at the national level. Can you tell us what has come of this recommendation? Also, I'm curious as to the initial stimulus for such a recommendation. Basically, was it the Ministry that wanted to give birth to a council at the national level?

Mordechai Shani: The Netanyahu Commission basically did two things. One was to set up a national council, established according to the new National Health Insurance Law. The nominations will be made within a few days. According to the law, the council will comprise 46 representatives from a very broad range of fields. Not all of them will be professionals. For example, the sick funds in Israel will be asked to send ten representatives to the council. The municipalities will have three representatives. This national council will get recommendations from the specialty councils and will have to set priorities; the national council is a different type of council than the specialty councils. The aim of the national council is to reflect what the community is thinking, to discuss ethical questions, maybe to hear professionals who will come to testify. The Netanyahu Commission did not discuss the idea of a professional council.

The second thing the Netanyahu Commission recommended was not a council, but an authority. This was written up in the majority report of the Netanyahu Commission, but it has not yet been implemented. The Commission discussed establishing a National Health Authority, which would be responsible for regulating and overseeing the provision of health services. Practically, I am not sure that such an Authority is a necessity. Although I sided with the majority, I might accept the opinion of the minority here. In the meantime, no such Authority has been established. However, we have been trying to change the nature of the work of public health officers. We would like Israel's six public health officers to oversee and supervise the provision of health care. Whether we need an Authority above them or not, I don't know.

Dr. Adnan Hammad, *Senior Health Planner at the Planning and Research Centre, Jerusalem*: It always strikes me when I hear the words or phrase "performance indicators", that these are actually very much related to quality of health, and stem from good management practices. We have heard you speaking about the reform of the Israeli health care system, and from the professional point of view, it seems very advanced. What are the management tools you are using to achieve quality of health care? Are management practices actually dealt with in your policies? What are the major standards for management practices that will produce good quality health care?

Mordechai Shani: Until 1986, there was no institute in our universities which really taught administration. In 1986, due to pressure from the government, Tel Aviv University opened a Masters' degree program in administration. Meanwhile, Ben-Gurion University in Beer Sheva established a program in management. The School of Public Health at the Hebrew University in Jerusalem is also trying to educate people in management. Thus, we now have three universities in Israel that are educating people in health management at a Masters' degree level. In addition, we are trying to educate managers already in the system through supplementary seminars and special courses. We call them the "desert generation", although they don't like this definition.

Unfortunately, one of the recommendations of the Netanyahu Commission -- that after a cut-off year, perhaps 1996 or 1997, no director of a clinic or a hospital will be appointed without having an academic degree in health management -- has not yet been implemented. This is due to the pressure of the unions. Nevertheless, it seems that many other medical professionals besides administrators are going to universities for degrees in management. Physicians, nurses, even physiotherapists are leaving their medical careers and going towards management. This represents a new concept of management. The current administrators were not trained. The union doesn't understand that you need to be trained.

To this end, we are also sending some of our managers abroad. We have arrangements with Harvard University and Brandeis University regarding scholarships for people who spend at least one year abroad to be trained. For example, the director of the Department of Technology and Quality at the Ministry of Health returned to Israel after spending two years learning management and quality of care abroad. Without any doubt, the world is leaving administration and going toward management. Without educating and re-educating managers, there will be no way to improve quality. One thing you will have to do is find a place or places where directors will be able to

engage in dialogue and learn, because this is very, very important to the advancement of services. For example, although training and education of managers is excellent in England, in many hospitals outside London that have become trusts, the directors have not received further training. In other English cities, even large cities like Birmingham, no effort has been made to retrain or re-educate administrators and heads of medical departments.

Moreover, we are slowly trying to push heads of medical departments to understand the economic aspects of their decisions. There is no other way to do this but to teach them about the changes in health care delivery throughout the world.

Dr. Issa Qassees, *Coordinator of the Health Insurance Unit, Palestinian Council of Health*: Basically, I'm interested in finding out how Israel is handling the issue of malpractice so that it will not reach crisis proportions and drive the cost of medical care way up.

Mordechai Shani: There are two aspects to malpractice; I understand you are referring to the insurance aspect. What we are trying to do -- and I have a feeling that we are a little late -- is three things. First, following a government decision, a committee was established to investigate whether we can deal differently with malpractice. For example, the Clinton Administration proposal for health care reforms, which is unfortunately not being implemented, proposed seeking arbitration before going to court; and in several states in the United States, like California, there is a ceiling on the fine a court can levy in a malpractice case. This committee, which comprises lawyers and physicians and is chaired by a judge, will make its recommendations within two months.

Second, we are thinking about instituting a captive market of insurance. Why let private agencies earn money off us? Since Israel currently has more than 15,000 physicians -- 10,000 in the Ministry, the General Sick Fund and Hadassah Hospital alone -- the idea has been raised of establishing a captive market, in which insurance premiums would be smaller. Someone in the United States has spent the last half year assessing what is occurring there in relation to captive markets. We got the report three weeks ago and I do believe that beginning next year, we shall move to establish one insurance market for most of the physicians in Israel.

Third, by implementing risk management -- mainly in hospitals but also in the community -- and by aggregating all data, we could prevent mistakes in the

future. As I said, the risk management of Kupat Holim Clalit is good. We are talking about setting up the same thing in the Ministry of Health. We are negotiating with the Israeli Medical Association to establish a team of experts that will collect relevant data, analyze it, and inform hospital directors and experts where the repeated mistakes are.

Prof. Dan Michaeli, *Chairman of the Board of Directors, Kupat Holim Clalit*: Just one remark before I make some comments. You forgot to mention, Prof. Shani, that we have a diploma program of specialization in health care management for physicians, whose diploma is recognized as being on the same level as diplomas in medicine or surgery or whatever. This is probably the only place in the world where a specialized diploma in health care management is issued to physicians by the Ministry of Health.

I would like to point out that everyone can agree with all the ideas you have heard, all the comments -- it is very easy to agree with them. But the total picture is one of a very strong concentration of power in the hands of the Ministry of Health. This is a difficult issue for providers -- and I'm speaking as a provider, both at Kupat Holim Clalit and in my previous job as director of a hospital. One thing which was missed, was that the legislation to establish a national health council was not intended to establish a council where recommendations would be discussed on a semi-social basis. Rather, it was to mandate the creation of an agency that would authorize the system to include or remove certain specific services from the basket -- that is, define the basket of services. Unfortunately, as you have seen, things have developed such that you have these professional bodies within the Ministry that work directly with the Ministry, by-passing what the law was intended to create: a publicly-managed system that could dictate to the government concerning what should or should not be included. There are several repercussions to this, but I don't want to take up too much of your time.

I think we have to remember one thing. Competition is not only bad. We in the health care system have an interest in encouraging competition to attract more resources. On the other hand, we have a national responsibility to contain it. But not leaving any field for real competition, not leaving any "breathing space", may be very detrimental to the development of the system in the long run.

Mordechai Shani: I would like to note that on the 18th of December, 1995, there will be an international conference on governments and the delivery of health care, at which Robert Evans will be the keynote speaker. Four working

groups will discuss technology and quality, financing, and promotion of health care, as well as the role of the government in the delivery of health care.

I would like to mention an article by Prof. Brown of Columbia University, which was published in the summer of 1993. What Brown says is very interesting: he says that while there is privatization in the United States in telecommunications, aviation, etc., when you analyze the health care system there, the trend is the opposite -- there is much more regulation. The trend around the world is for providers to be independent in day-to-day activities, but for Ministries of Health to set priorities. Competition is excellent. Unfortunately, in Israel it has caused a situation where Kupat Holim Clalit will soon be Israel's Medicare and Medicaid. Therefore, there has to be government, and government has to establish a recovery plan and oversee how competition is handled in the system.

Dr. Nadeem Toubassi, *Director-General of the Palestinian Health Authority in the West Bank*: I would like to ask two questions. The first is, what is the legal relationship between the Israeli Medical Association and the Ministry of Health, especially for licensing of doctors and other certifications? The second question is, does the Ministry of Health play any part in running Magen David Adom (Israel's trauma and emergency services) and if so, is this grounded in rules and regulations issued by the Ministry of Health? Many Palestinian voices are calling for us to set up something similar to Magen David Adom. Thank you.

Mordechai Shani: First, there is no official legal relationship between the Medical Association and the Ministry. The Medical Association is an independent agency. The Ministry of Health issues licenses to physicians. The only area in which the Israeli Medical Association plays a role is regarding specialization. The Association has a Medical Council which supervises all residency programs; basically, the Council decides who will be a specialist and who will not. Furthermore, they supervise the departments that provide residency programs. While they make recommendations, it is the Ministry that issues licenses. The physicians recently demanded that licenses be issued to them as they are to lawyers -- that is, a council of lawyers issues licenses. We did not agree to this, nor shall we agree in the future. We had a very strong debate this past year with the Medical Association, and especially the Medical Council, regarding quality of care. They wanted to be the overseer of quality and we refused. They could be a major partner. We would like to have them as major partner, because we don't want to antagonize the medical community. But there are other professionals to think about, not

to mention the public -- and we have to reassure the public that the Ministry is supervising. Therefore, the council may be an excellent partner, but we must decide about quality of care.

As for Magen David Adom, there is a law defining the rules concerning its operation. Officially, the Ministry is not responsible for the provision of trauma and emergency services. Due to the collapse of the financing of Magen David Adom several years ago, there was an interim period -- up until a year ago -- during which the Ministry of Health took over the financing of, and some of the responsibility for, Magen David Adom. However, this again involved the Ministry in the provision of health care, and it is better that Magen David Adom be independent, and not a government association. While we're talking about Magen David Adom, I'd like to relate to one bad aspect of it -- and you should learn from our mistake. It should be the case, and indeed is in some countries, that primary care physicians are on duty at night, on a rotation basis. Unfortunately, this is not the case in Israel. The clinics run by our sick funds are closed at night, and Magen David Adom has an arrangement with physicians, who earn a lot of money for being on duty in the evening and at night. This is not good. When you organize your primary care system, try to arrange that your physicians are on duty for 24 hours. This is a much better arrangement. Magen David Adom is excellent regarding emergency services, but not regarding night duty arrangements.

Dr. Shawqi Harb, *Director of Ramallah Hospital*: It is no secret that we are in the process of establishing a Palestinian Medical School. Could you shed some light on the relationship between Israeli medical schools and the Ministry of Health? A second question, which is probably related, is how did you cope with the influx of physicians from all over the world? We have a similar situation. Do medical schools have a role to play in this or is it a matter for the Ministry of Health?

Mordechai Shani: First of all, we have not coped with the influx of physicians. We cannot cope. No country could cope. You have to remember that before the major Russian immigration of 1989, Israel had 300 physicians per 100,000 people, while the United States had 220, and Japan and England only 160. So we, like Germany and Sweden, were kings in the Western world as regards the number of physicians per capita. Yet Russia had 450 physicians per 100,000 people. There was even a joke in the literature that instead of complicated equipment, the Russians were producing physicians. We got many of them. We cannot cope. We don't need them, but we have to accept them. Twelve thousand five hundred people came to Israel claiming that they

were physicians. Then ten thousand of them presented us with papers to prove it. But we have strict laws about examination and licensing, so up until now, only 3,500 have been licensed. Of course, this is the responsibility of the Ministry. Some of the universities have organized courses for these physicians. Furthermore, in some cases, we try to convince physicians to change their profession. We then retrain them to work with communication disorders, or as physiotherapists, etc. -- especially if it is not clear that they were physicians in Russia. The retraining courses are also organized by the universities. So there is a very strict licensing mechanism. First, you have to issue licenses to legitimate physicians. Then you have to decide what level of quality you will accept from physicians, and re-educate or retrain them as appropriate. Of course, there is also a free market. We did not increase the number of posts in our public health system, even though there was a demand that we do so. It was even suggested that we employ these physicians to take blood from patients, instead of having licensed physicians do this. But we did not yield to any pressure. No more posts, we said. You must try to compete with other physicians from other places.

As for medical schools, basically, there is no relationship between the Ministry of Health and the medical schools. Each university is independent. We have an informal relationship with the universities. What we have tried to do, through the Israeli Council for Higher Education, is to provide money so that people in remote hospitals, in peripheral hospitals, can get academic degrees from universities. But we have no other official relationship.

Jack Habib: We'll take the last question from Prof. Pinchas, who was a member of the Netanyahu Commission, and who is, of course, Director of the Hadassah Hospital.

Shmuel Pinchas: I would like to make a comment, not ask a question, on the very clear and coherent presentation given by the Director-General. As this is an academic forum, allow me to make an academic comment.

It was extremely interesting to me that three director-generals -- two current and one former -- have brought up the issue of how to run a health care system in the modern world: that is, whether to do it through a hierarchy, or market forces, or a combination of the two. Academically, this was settled long ago. Under conditions of severe rationing and lack of resources, a hierarchical system is much better. This has been proven repeatedly. I would urge our Palestinian colleagues to concentrate on a hierarchical system for the first ten years. I assure you, you will be not making a theoretical mistake.

You cannot avoid the issue of a long border with a richer and more advanced neighbor. When the Canadian government instituted its harsh administrative capping, the northern border of the United States flowered. Wonderful places developed, like the famous Fargo Clinic of North Dakota -- a totally unknown little place until the Canadians capped funding and the Clinic expanded to seven times its size in three years. The owners -- doctors -- have become extremely rich over the past three years. You should think of what you want to do about your neighbor. My suggestion is that you bow to your inclination toward market forces only as far as your neighbor is concerned. There was a wonderful book published in the early 1970s called *Hierarchy and Markets* -- by Oliver Williams, I think. (It was published in America, I think by the Free Press -- I have the full Library of Congress number back in the office, and I'd be glad to give it to any of you.) It deals with these issues. Hierarchy is the way to go. As for the market part of it, leave that to trans-border commerce. And the way to do that is just to forget about it. Don't think about it. Just leave it be. That's all.

Mordechai Shani: I would like to add one comment. Prof. Pinchas and myself were in the majority on the Netanyahu Commission. So at least there we agreed. Now we represent opposite sides -- I the Ministry, and he the provider. Today we have heard two providers talk about rationing. My friends, believe me that in Israel there is a lot more to do besides rationing. For example, Prof. Gottesman, the director of the council on cardiovascular diseases, told us of the surprise of cardiologists on hearing that Hadassah Hospital in Jerusalem does not permit him to order unlimited numbers of ergometry tests, and that he therefore does catheterizations instead of ergometry tests. Obligatory clinical guidelines on this will be introduced in Israel next year. Thereafter, neither the Ministry nor the sick funds will pay for catheterizations not performed in accordance with the clinical guidelines. I can assure you that we shall earn a lot of money; but this is the international game between governments and providers. A thank you to all our colleagues -- we are here to share ideas and views with you. Thank you.

(After a break for lunch, the Working Groups Session took place.)

Summaries of the Four Working Groups

Jack Habib: I'd now like to open the final session, in which we will hear reports from the various working groups and, if we have time, exchange a few words of general discussion. We will proceed in the order in which the groups appear on the list. I would like to invite Dr. Yehia Abed and Mr. Gabi Bin-Nun to come up and present the report of the working group on the reorganization of the Ministry of Health. But I see you've delegated presentation to someone else -- I remember there was a very democratic process of delegation.

Reorganization of the Ministry of Health (Group A)

*Presenter: **Dr. Varsen Shahin**, Coordinator of the Human Resource Development Unit, Palestinian Council of Health*

The group discussed the concept of reform of the health care system in Israel, and reached the conclusion that the Palestinians need not start as the Israelis did in 1948. The Palestinians have to learn from and avoid the mistakes of others, and create a national body responsible for health care capable of exercising power and capitalizing on the work of providers in the context of a clearly-articulated, all-encompassing development strategy.

The Palestinians have to create their own health care system model, based on what exists and based on the experiences of others. The Palestinian national health care system needs to be empowered to become the leader, policymaker and coordinator -- especially during the critical stage of inheriting the health care system in Gaza and the West Bank previously administered by the Israelis.

In the process of building the Palestinian health care system, and especially during these turbulent times, the providers of health care -- including the Ministry of Health, the Palestinian Council of Health, UNRWA, the NGOs and the private sector -- have to complement each other. There is a role for each of them in the health care system. They must work toward the overall goal of improving health care for, and the health status of, the Palestinians; they must learn to manage health care under independence.

The roles and functions of the Palestinian Council of Health (PCH) and the Ministry of Health have to be clarified. Special emphasis should be placed on the active role of the Ministry of Health in planning, policy-making, monitoring and evaluating. The role of the PCH will be clearly articulated when Palestinians assume full responsibility for the health care system in Gaza and the West Bank.

Jack Habib: You left out just one thing, Dr. Shahin. You didn't say anything about the Israeli Ministry of Health. That's because the Israelis in your group decided it was a lost cause. My friend from the Ministry will know that that's said in good spirits. We'd like to move on to our next group, the Health Insurance Group. How are we going to finance all of these things? I'd like to ask Dr. Bruce Rosen and Dr. Adnan Hammad to come up. Dr. Hammad is going to give the report.

Health Insurance (Group B)

*Presenter: **Adnan Hammad**, Senior Health Planner at the Planning and Research Centre, Jerusalem*

With reference to health insurance, we found that the Palestinians are doing fine. As a matter of fact, most of our Israeli colleagues are very jealous of us, because we don't have as many complicated issues as they have, such as referrals and basket of services, etc.

However, there are common issues, issues we agree upon, and there are Israeli issues and Palestinian issues. Regarding the common issues, we agreed upon the following: hospitals should be separate, not part of the health system. A health tax -- whether from general taxes or earmarked taxes -- the insurance system in general, the delivery system, and patient choice were discussed in the general context of our session.

As regards the Palestinian issues, the discussion was quite heated. Our Israeli colleagues were very enthusiastic about helping in the development of our insurance scheme, both now and in the future. The topics or issues raised were as follows: what type of insurance are the Palestinians going to have -- comprehensive, obligatory, voluntary, or all of these? We talked about the relationship between insurer and provider. Willingness to pay for insurance, an issue raised in our discussion, is closely related to ethnic, religious and traditional frameworks. As one of our colleagues mentioned, people think that

when they pay money for insurance, they are betraying their faith or going against religious tradition or something like that. This is a problem.

Demographic factors were also discussed. You know that about 50% of the Palestinian people are 14 years of age or under. So our insurance costs and our health service costs are not going to be very expensive, compared to those of other nations. However, we project that the number of people aged 65 years old or older will increase in the future. A capitation system is one we would recommend to the Palestinians, with providers fully responsible for their patients. We will have to take into account many things -- such as preventive medicine, waiting lists, etc.

The issues related to the Israeli side were as follows: one of the good things about Israeli health insurance is that it has one single arrangement, and system organization is quite efficient. How broad or specific the basket of services is, and the problem of waiting lists, were discussed thoroughly. We recommend a follow-up in six months' time, to re-evaluate what has been achieved. We call on the AJJDC to take the initiative and conduct such a seminar in the future, just to see how we are doing. Thank you very much.

Jack Habib: So now that we have a Ministry and lots of money to spend, let's hear how we are going to spend it. Dr. Nadeem Toubassi and Dr. Yitzhak Peterburg will tell us.

The Service Provision System (Group C)

*Presenter: **Yitzhak Peterburg**, Executive Director, Central District, Kupat Holim Clalit*

The short workshop began with a presentation of the main forces and challenges in both the Israeli and the Palestinian health care systems, and a fruitful discussion followed. We tried to identify the main issues that need to be addressed regarding the provision of services in these systems. The first issue was harmonization, the problem of harmonizing the different health care providers, which leads to the problem of differing policies. Examples were given of the differing policies of institutional versus home delivery, and of systems that are based on insured versus free services. The problem of harmonization also leads to the problem of duplication of services in some areas and deprivation of services in others. This raises the question of how to better allocate the scarce resources of the system.

The second issue concerned the lack of appropriate resources for primary or community care. The third issue concerned the need to define the **basic** -- and this is the most important word -- the basic benefit package. In other words, you need to set priorities because there is not enough money for everything.

Fourth, you also need to set the boundaries -- that is, to set the rules of the game -- between hospital services and community services. If you do not do that, you are going to be paying twice for the same service. The fifth issue, which was also raised by the other groups and at the plenary session, concerned the problem of relevant information: that is, given the flood of information available, being able to determine what is relevant and what is not.

The sixth issue was that of community support systems for the ill, which require appropriate use of manpower. In particular, we discussed the role of nurse practitioners in the community, for example as delegates of all the health services. Questions about midwifery were also raised.

The seventh issue, which was very "hot", and which I think is very important, was distribution of services. We discussed the Israeli experience with regionalization, and how it might or might not be applied to the Palestinian situation.

The eighth issue was that of building a system of referrals from primary to secondary care using one of two models: either hospital-based secondary care, or community-based secondary care. The ninth issue concerned immunization policy. Most of the participants addressed the problem of vaccine supplies and what they are going to do in 1995.

I tried to get "ten commandments", but found myself with eleven. The last two issues were connected, as they both involve better training. The tenth issue was better training for health care providers, especially family physicians. The eleventh issue concerned better training for managers. Participants discussed holding joint workshops for managers working in similar settings, such as hospital settings, to enable them to learn from each other. Thank you.

Jack Habib: Now we have lots of health care providers earning lots of money; the question is whether any of our clients are going to benefit from all these services. This brings us to the question of quality of health care, which will be discussed by Prof. Leon Epstein and Dr. Rashad Massou.

Quality of Health Care (Group D)

*Presenter: **Prof. Leon Epstein**, Head of the Department of Social Medicine, Hadassah Medical Center*

I think I should start by saying that we asked ourselves that question, and the answer was: we don't know. I think the Israeli members of the group were very envious of the overall national plan which Rashad (Dr. Massou) presented to us, and the discussion -- which I felt was very productive -- covered a number of components of that plan, as well as some aspects of the Israeli experience. This raised problems and questions related to the role of quality, its priority, who is going to pay for it and how we can ensure it. I will pull out a number of points from the discussion. However, there were many salient points, and I'm not quite sure that everyone will agree with those I've chosen.

The first point, which was discussed fairly extensively, was whether quality of health care should be dictated, planned, and controlled at a national level, or whether quality of health care is the responsibility of an institution, a service or a professional entity. As someone said about three-quarters of an hour into the discussion, one could have gotten the impression that quality was what doctors provide, until someone drew our attention to the fact that there are other people working in the health services. I think the question of quality of health care concerns far more than the quality of the physician's functioning, but concerns nurses, physiotherapists, and other health professionals as well. We also felt that quality of management is an area that needs to be highlighted. How to ensure quality of care will be discussed at the next workshop.

The second point was the role of information. A question was raised as to whether the systematic collection of data, and its analysis and interpretation, can itself change quality. It was felt that it can. Experience from other countries seems to illustrate this. The whole question of the systematic collection and utilization of data to ensure quality, and the role of monitoring, were central to the plan put before us. They also relate to another question: should an overall quality program be in-depth -- directed towards individual clinical or health units -- or should it be broad and on a general level, addressing the question of quality in general? It was asked whether action taken in one clinical unit has a halo effect on quality in an entire institution. There were two diametrically opposed opinions about this: one held that it definitely does and the other that it probably does not. So we're going to leave this up to you.

A very interesting point was raised: that quality is very closely related to the socio-cultural milieu of the professionals in an institution and, no less important, to that of the clients who use that institution. Therefore, we cannot assess the quality of an institution in terms of another institution's cultural framework, that is the framework of the professionals or of the clients involved.

Rashad mentioned the need for a national survey of quality indicators. A discussion began concerning whether a national survey of quality indicators could provide a basis for planning. I think this subject is beyond the scope of our discussion, but obviously the content of such a national survey, and its cost, are important. This topic will be included in the first or second round of discussions in the coming six months or so; we're going to come across this material further on down the road.

Another important point concerned data on health measures presented today both at the plenary session and in our group: that is, data on infant mortality and mortality in general. The point was very well made, I think, that national figures on mortality do not reflect variations in mortality rates among regions, or variations in health status or in standards of provision of care among regions. Therefore, one cannot accept a national infant mortality rate of either 12 or 41 per 1000, for example, as reflecting the situation across a country, as it may hide very important differences among different regions.

Lastly, the question of training and training for quality -- especially quality management -- was raised. Management exists at all levels of a system; thus, we are talking not only about managers at the CEO level, but about individuals at every level who have a management role. If we believe that quality in management is critical to the quality of care provided, training must reach people at all levels and in all professions, in whatever framework they are studying. Thank you.

Jack Habib: Now that everything is in place, and the health system is ready to roll, I'm sure someone is going to come along and spoil everything, saying we forgot something critical or we made a mistake, or our data is wrong. Prof. Shani, I'm sure, is still convinced that the deficit is too high, and is going to send you a letter about the numbers involved because he is always so careful. He sends everybody letters about their numbers. But all kidding aside, we do have a little bit of time left for discussion, if anybody would like to raise any additional points.

General Discussion

Dr. Yasser Obeid, *Director of Hospital Services in the West Bank*: I want to ask the first group about the reorganization of the Ministry of Health. This was the subject specified, but in the summary given, we didn't hear anything about the reorganization of the Ministry of Health.

Gabi Bin-Nun, *Deputy Director-General of Health Insurance and Economics, Israeli Ministry of Health*: We started the meeting by describing the reorganization of the Ministry of health in Israel, but as there is no Ministry of Health in the Palestinian Authority, there was nothing to say about reorganization there. Basically, most of our discussion was about planning for the future, not just for the Ministry of Health but for the role that other institutions will play in the delivery of health services in coming years. There was some confusion, in my view, among the Palestinians: certain issues that are very clear to us because our state is 45 years old seem less clear to them. This is because they haven't had the experience of having a state or independence, from which to learn or build upon. That's why you didn't hear about reorganizing the Palestinian Ministry of Health from us or our group. We were thinking about the future.

Jack Habib: Does anyone else from the group want to respond to that question? I might just add that there was a lot of discussion of the role of the Ministry as a provider versus a regulator of services, the extent to which it should provide services, and the role of government services versus voluntary ones. So we did get into that critical issue quite a bit.

Dan Michaeli: I'd like to propose that the phrase "avoid conflict of interest" be used when describing the role of the government and that of the providers. We haven't avoided it in Israel and are paying dearly for it. The reorganization of the Ministry is aimed in a way at disassociating the Ministry from its responsibility for providing services. If we do not succeed in doing this, then our slogans will remain slogans, and will have no practical effect on improving health services.

Dr. David Chinitz, *JDC-Brookdale Institute*: I was impressed with all the discussions and reports, but I think that with the exception of some of the Palestinian speakers in the health insurance group, no-one addressed the question of perceptions, particularly religious ones, that might prevent or impede the expansion of insurance. I didn't hear too much about the role of

the public, the perceptions of the public, accountability to the public and what the political leaders who are designing the two health systems can or should do in these systems, each of which is undergoing a very significant transformation. That is, what is being done, what should or can be done, to involve the public, engage the public and generate a sufficient amount of social solidarity to run a health system?

Riad Zanoun: We started a lot of activity to get the community involved in national health insurance. We did this through the media, and through workshops. We held workshops with medical and paramedical staff and with beneficiaries; then we went to the universities, and to the national syndicates and organizations; and we really didn't feel any resistance to the idea of national health insurance -- even among the most extremist Hamas people. So I am slightly astonished at the idea that religion might hinder this. Those who know the Islamic religion know quite well that the only objection is to life insurance. Some scholars of Islam put a question mark on life insurance, but never on car insurance, for example.

Becky Bergman: I hope I'm not out of line, and please forgive me if I'm a little bit emotional, but I want to note not what was missing today, but what was a bonus. I never once felt a sense of "them" and "us". The feeling I had during this meeting -- both at the plenum and in my working group -- was exactly the same feeling I have when I sit with the nursing colleagues or interdisciplinary colleagues I've worked with most of my life, some of whom were my students and some of whom were my teachers. I can't help saying that I'm very grateful -- as I'm sure we all are -- to all of you for giving us this feeling of togetherness, of oneness. We haven't had it for a few years, and I think it's time we did. I certainly had that feeling today, and I'm sure it is going to continue and grow. Thank you so much.

Jack Habib: After that statement, I think there is only one thing to do, and that is to end the meeting. I just want to say a couple of words about continuation. A group of the Palestinian leaders and the Israeli leaders, together with AJDC representatives, will be meeting tonight to discuss and sum up what has happened here today, and to discuss possible further steps and activities. All I can say is that my own organization is fully committed to being a facilitator, to being part of this process, to being helpful in any way we can. I think it would be most appropriate if I asked Dr. Zanoun to make the final remarks. I'm taking him by surprise, but I hope he'll respond favorably despite that. Thank you everyone and see you soon, I hope.

Riad Zanoun: I would really like to thank everybody, especially hearing the emotional but sincere and deep-hearted comment we just heard. Ladies and gentlemen, I think you can be proud of what you have done today. We have taken the first step on a long march, an important one, toward continued cooperation, for the sake of our children, ourselves, our present and our future. I think this should be the first of many meetings and that the AJJDC should prepare a lot of meetings like this, because we feel this is an effort that deserves to be continued with strong momentum. Thank you.

Appendix A: Seminar Agenda

Monday October 31, 1994

08.30 - 09.00 **Gathering**

09.00 - 09.30 **Greetings:**

Dr. Ephraim Sneh
Minister of Health, Israel

Dr. Riad Zanoun
Minister of Health, Palestinian Authority

09.30 - 12.00 **Session I - Keynote Addresses**
Chairperson: Prof. Jack Habib
Director, JDC-Israel and Director, JDC-Brookdale Institute

09:30 - 10:30 Presentation of the Palestinian Health Plan
Dr. Rafiq Husseini
Director, Palestinian Council of Health
Assistant Deputy Palestinian Minister of Health
(Lecture and Discussion)

10:30 - 11:00 **Coffee Break**

11:00 - 12:00 Presentation of the Israeli Health Reform
Prof. Mordechai Shani
Director General, Israeli Ministry of Health
(Lecture and Discussion)

12:00 - 12:10 **Description of the Logistics of the Working Groups**

12:10 - 13:00 **Lunch Break**

13:00 - 14:00 **Session II - Working Groups:**

A. Reorganization of the Ministry of Health
Co-Chairpersons:
Dr. Yehia Abed
Coordinator of Central Units, Palestinian Council of Health, Gaza
Director, Gaza Health Services Research Center
Mr. Gabi Bin-Nun
Deputy Director General for Health Economics, Israeli Ministry of Health

B. Health Insurance
Co-Chairpersons:
Dr. Bruce Rosen
Coordinator, Health Policy Research Program, JDC-Brookdale Institute
Dr. Adnan Hammad
Senior Health Planner, Planning and Research Center

C. The Service Provision System
Co-Chairpersons:
Dr. Nadeem Toubassi
Director General, Palestinian Health Authority
Dr. Yizhak Peterburg
Executive Director, Central District, Kupat Holim Clalit

D. Quality of Health Care
Co-Chairpersons:
Prof. Leon Epstein
Head, Department of Social Medicine, Hadassah Medical Center
Dr. Rashad Massoud
Coordinator, Quality of Health Care Unit, Palestinian Council of Health

14:45 - 15:15 **Coffee Break**

15:15 - 16:00 **Session III - Summary**

Presentation of Working Groups' Main Issues
Discussion and Summation

Appendix B: List of Participants who Attended the Seminar

Dr. Yehia Abed
Coordinator of Central Units, Palestinian Council of Health -- Gaza;
Director, Gaza Health Services Research Center
Gaza

Tel: 07-829173 or 829174, Fax: 07-869820

Dr. Dina Abu Shaban
Coordinator, Unit for Inter-Sectoral Cooperation
Palestinian Council of Health
Gaza

Tel: 07-863282, Fax: 07-869820

Dr. Abdel Jabbar Al Tibbi
Director, Primary Health Care
Palestinian Ministry of Health
Gaza

Tel: 07-829173 or 829174

Ms. Dena Asfour
International Cooperation Unit
Palestinian Council of Health
P.O. Box 51681
Jerusalem

Tel: 02-272963, Fax: 02-274059

Prof. Alexander Aviram
Director, Assuta Hospital
62, Jabotinsky Street
Tel Aviv 62748

Tel: 03-5201510, Fax: 03-524434

Ms. Tamara Barnea
Coordinator, AJJDC Israeli-Palestinian-Arab Program
JDC-Israel and JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557437, Fax: 02-635851

Prof. Rebecca Bergman
Department of Nursing
School of Health Professionals
Tel Aviv University
Ramat Aviv

Tel: 03-6408394

Dr. Yitzchak Berlovitz
Head, Medical Services
Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 91010

Tel: 02-705978, Fax: 02-705726

Mr. Gabi Bin-Nun
Deputy Director-General, Health Insurance and Economics
Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 91010

Tel: 02-705963, Fax: 02-785453

Ms. Jenny Brodsky
Head, Unit for Research on Aging
JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557400, Fax: 02-635851

Dr. Martin Cherkasky
Honorary Vice-President, American Jewish Joint Distribution Committee
Montefiore Medical Center
111, East 210th Street
Bronx, N.Y. 10467
U.S.A.

Tel: 001-718-920-4001, Fax: 001-718-231-1960

Dr. David Chinitz
Researcher, JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557391, Fax: 02-635851

Dr. Samir El Khatib
Director, Public Health Laboratories
Palestinian Ministry of Health
Gaza

Tel: 07-829173

Prof. Leon Epstein
Head, Department of Social Medicine
Hadassah Medical Center
P.O. Box 12000
Jerusalem 91120

Tel: 02-777448, Fax: 02-434434

Mr. Haim Factor
Deputy Director, JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557117, Fax: 02-635851

Mr. Abdul Fattah-Affifi
Coordinator, Finance Unit
Palestinian Council of Health
Gaza

Tel: 07-863282

Dr. Mario Ferraro
Representative, World Health Organization
c/o American Colony Hotel
Jerusalem

Tel: 02-282421, Fax: 02-283557

Prof. Joel Fleishman
Terry Sanford Institute of Public Policy
Duke University
508, Fulton Street
Durham, N.C. 27705
U.S.A.

Tel: 001-919-286-6860, Fax: 001-919-186-6861

Dr. Rachel Fleishman
Senior Researcher, JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557438, Fax: 02-635851

Ms. Revital Gross
Senior Researcher, JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557419, Fax: 02-635851

Mr. Shraga Haber
Senior Deputy Director-General, Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 91010

Tel: 02-787618, Fax: 02-785453

Prof. Jack Habib
Director, JDC-Israel and JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91034

Tel: 02-6557111, Fax: 02-661244

Mr. Salah Haj Yehia
Association of Israeli-Palestinian Physicians for Human Rights
P.O. Box 10235
Tel Aviv 61101

Tel: 03-5250526, Fax: 03-5250527

Dr. Adnan Hammad
Senior Health Planner, Planning and Research Centre
P.O. Box 51681
Jerusalem

Tel: 02-826697, Fax: 02-816236

Mr. Meir Handelsman
Director, Health Information Systems and Computerization
Israeli Ministry of Health
107, Hebron Road
Jerusalem

Tel: 02-720568, Fax: 02-706895

Dr. Shawqi Harb
Director, Ramallah Hospital
Ramallah

Tel: 02-982222

Dr. Arafat Hidmi
Director of Health Services -- West Bank
UNRWA Field Office
P.O. Box 19149
Mount Scopus
Jerusalem

Tel: 02-282435

Dr. Rafiq Husseini
Director, Palestinian Council of Health;
Assistant Deputy Minister of Health for the Palestinian Authority
P.O. Box 51681
Jerusalem

Tel: 02-276001

Ms. Shifa Jayousi
Assistant Coordinator, Planning Unit
Palestinian Council of Health
P.O. Box 51681
Jerusalem

Tel: 02-272963, Fax: 02-274059

Ms. Malka Korazim
Senior Researcher, JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557418, Fax: 02-635851

Prof. Mitchell W. Krucoff
Director, Ischemia Monitoring Laboratory, Duke University Medical Center;
Director, Cardiac Catheterization Laboratory, VA Medical Center
Durham, N.C. 27705
U.S.A.

Tel: 001-919-286-6860, Fax: 001-919-186-6861

Dr. Ibrahim Ladaa'
Director, Augusta Victoria Hospital
Jerusalem

Tel: 02-279911

Dr. Boaz Lev
Deputy Director-General, Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 91010

Tel: 02-705706, Fax: 02-783266

Dr. David Levanon
Medical Division
Kupat Holim Meuchedet
124, Ibn Gvirol Street
Tel Aviv 62038

Tel: 03-5202381, Fax: 03-5227767

Dr. Alex Leventhal
Head, Public Health Services
Israeli Ministry of Health
20, King David Street
Jerusalem 91010

Tel: 02-247850, Fax: 02-233058

Mr. Leon Levy
International Development Program Committee
American Jewish Joint Distribution Committee
711, Third Avenue
New York, NY 10017
U.S.A.

Tel: 001-212-687-6200, Fax: 001-212-370-5467

Ms. Henryka Manes
Director of Operations, International Development Program
American Jewish Joint Distribution Committee
711, Third Avenue
New York, NY 10017
U.S.A.

Tel: 001-212-687-6200, Fax: 001-212-370-5467

Dr. Ruchama Marton
Chairperson, Association of Israeli-Palestinian Physicians For Human Rights
P.O. Box 10235
Tel Aviv 61101

Tel: 03-5250526, Fax: 03-5250527

Dr. Rashad Massoud
Coordinator, Quality of Health Care Unit
Palestinian Council of Health
P.O. Box 51681
Jerusalem

Tel: 02-272963, Fax: 02-274059

Mr. Suffian Mshasha
USAID West Bank/Gaza
American Consulate General
18, Agron Street
Jerusalem

Tel: 02-253288 or 253201, Fax: 02-259484

Prof. Dan Michaeli
Chairman, Board of Directors
Kupat Holim Clalit
101, Arlosorov Street
P.O. Box 16250
Tel Aviv 62098

Tel: 03-6923310 or 03-6923287, Fax: 03-6969901

Ms. Mia Mohilever
Deputy Director-General for Budgeting and Pricing
Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 91010

Tel: 02-787618, Fax: 02-785453

Dr. Benjamin Mozes
Head, Clinical Unit for Research on Quality Assurance in Health Care
Gertner Institute
Sheba Medical Center
Tel Hashomer 52621

Tel: 03-5303516 or 03-5303517, Fax: 03-5303277

Prof. Lechaim Naggan
Vice-President and Dean of Research and Development
Ben-Gurion University of the Negev
P.O. Box 653
Beer Sheva 84105

Tel: 07-278994, Fax: 07-472930

Mr. Daniel Nevo
Israeli Ministry of Foreign Affairs
Jerusalem

Tel: 02-303515

Dr. Yasser Obeid
Director, Hospital Services -- West Bank
Ramallah

Tel: 02-955657, Fax: 02-955060

Prof. Gur Ofer
Hebrew University of Jerusalem
Mount Scopus
Jerusalem

Tel: 02-883238, Fax: 02-322545

Dr. Egbe Osifo
Health Specialist
World Bank
c/o Seven Arches Hotel
Jerusalem

Tel: 02-277555, Fax: 02-271319

Mr. Haim Peltz
Deputy Director, Budgets and Economics Department
Israeli Ministry of Finance
1, Kaplan Street
Jerusalem 91008

Tel: 02-317220, Fax: 02-317496

Prof. Shmuel Pinchas
Director-General, Hadassah Medical Organization
Ein Kerem
Jerusalem 91120

Tel: 02-776062, Fax: 02-420219

Dr. Yitzhak Peterburg
Executive Director, Central District
Kupat Holim Clalit
P.O. Box 15043
18, Jabotinsky Street
Rishon Le Zion 75232
Tel: 03-9687602, Fax: 03-9687605

Dr. Paolo Piva
Health Coordinator, General Directorate for Cooperation and Development
Italian Consulate
P.O. Box 4570
Jerusalem

Tel: 02-322904, Fax: 02-322904

Dr. Avi Porat
Department of Epidemiology
Ben-Gurion University of the Negev
P.O. Box 653
Beer Sheva 84105

Tel: 07-233303, Fax: 07-277342

Dr. Issa Qassees
Coordinator, Health Insurance Unit
Palestinian Council of Health
P.O. Box 51681
Jerusalem

Tel: 02-276001, Fax: 02-274059

Dr. Avi Ramot
Director, Division for Populations with Special Needs
JDC-Israel
P.O. Box 13087
Jerusalem 91034

Tel: 02-6557111, Fax: 02-661244

Mr. Will Recant
American Jewish Joint Distribution Committee
18, Jefferson Place N.W.
Washington D.C. 20036
U.S.A.

Tel: 001-202-223-6838, Fax: 001-202-223-2961

Mr. Shmuel Reznikovich
Deputy Administrative Director
Rambam Medical Center
P.O. Box 9602
Haifa 31096

Tel: 04-531689, Fax: 04-517443

Dr. Bruce Rosen
Head, Health Policy Research Unit
JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557460, Fax: 02-635851

Dr. Melhem Salman
Operations Officer
World Bank
c/o Seven Arches Hotel
Jerusalem

Tel: 02-277555, Fax: 02-271319

Mr. Yossi Shechter
Chief Administrator
Government Health Services -- Judea and Samaria
P.O. Box 17
Beit-El

Tel: 02-958758 or 02-958612, Fax: 02-958759

Dr. Yitzhak Sever
Chief Medical Officer
Government Health Services -- Judea and Samaria
P.O. Box 17
Beit-El

Tel: 02-982729, Fax: 02-958759

Dr. Varsen Shahin
Coordinator, Human Resource Development Unit
Palestinian Council of Health
P.O. Box 51681
Jerusalem

Tel: 02-276001, Fax: 02-274059

Ms. Nira Shamai
Director, Gertner Institute
Sheba Medical Center
Tel Hashomer 52621

Tel: 03-5303516 or 03-5303517, Fax: 03-5303277

Prof. Mordechai Shani
Director-General, Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 93591

Tel: 02-705706, Fax: 02-783266

Mr. Hossam Sharkawi
Coordinator, International Cooperation Unit
Palestinian Council of Health
P.O. Box 51681
Jerusalem

Tel: 02-276001, Fax: 02-274059

Dr. Raghda Shawa
Director, Nasr Hospital
Gaza

Tel: 07-865877

Dr. Abdul Rahman Shunnar
Director, Rafidia Hospital;
Director-General, Palestinian Ministry of Health -- West Bank
Nablus

Tel: 09-390390

Prof. Michael Silbermann
Chief Scientist
Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 91010

Tel: 02-705794, Fax: 02-781468

Dr. Ephraim Sneh
Minister of Health
Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 93591

Tel: 02-787626, Fax: 02-787662

Mr. Yossi Tamir
Director-General, National Insurance Institute
Jerusalem 91909

Tel: 02-709536, Fax: 02-519122

Dr. Jamal Tarazi
Health Specialist -- Gaza
USAID
Tel Aviv

Tel: 03-5255414, Fax: 03-5255549

Dr. Nadeem Toubassi
Director-General, Palestinian Health Authority
Ramallah

Tel: 02-957931, Fax: 02-955191

Dr. Theodore Tulchinsky
Coordinator for Public Health in the West Bank and Gaza
Israeli Ministry of Health
2, Ben Tabai Street
Jerusalem 91010

Tel: 02-782825, Fax: 02-785504

Ms. Karen D. Turner
Deputy Director, USAID West Bank/Gaza
American Consulate General
18 Agron Street
Jerusalem

Tel: 02-253288, Fax: 02-253201

Mr. Menachem Weinberger
Coordinator for Health Services in Gaza
Israeli Ministry of Health
P.O. Box 5
Industrial Area, Erez

Tel: 07-741540, Fax: 07-892593

Dr. Dan Yuval
Senior Researcher, JDC-Brookdale Institute
P.O. Box 13087
Jerusalem 91130

Tel: 02-6557454, Fax: 02-635851

Dr. Riad Zanoun
Minister of Health
Ministry of Health for the Palestinian Authority
Gaza

Tel: 07-829173 or 829174

Appendix C: List of Material Distributed to Participants

Material Distributed to All Participants

1. American Jewish Joint Distribution Committee. 1994. *International Development Programs (IDP).*

2. Chinitz, D.P.; and Cohen, M.A. (eds.). 1993. *The Changing Roles of Government and the Market in Health Care Systems*. JDC-Brookdale Institute, Jerusalem. (Monograph based on proceedings of conference held in December 1991).

3. Ellencweig, A.Y.; and Chinitz, D.P. 1993. "Israel's Health System Reform", *European Journal of Public Health*, 3:85-91.

4. Ministry of Health, State of Israel. 1994. *Health in Judea, Samaria and Gaza 1967-1994*. Government Printing Office, Jerusalem.

5. Planning and Research Centre (PRC). 1994. *The National Health Plan for the Palestinian People, Objectives and Strategies*. Planning and Research Centre, Jerusalem.

6. Planning and Research Centre (PRC). 1994. *The Palestinian Health Services in the West Bank and Gaza Strip, Facts and Figures*. Planning and Research Centre, Jerusalem.

7. Rosen, B. 1994. "Update on Major Developments in Israeli Health Care Since 1990", Paper prepared for the Israeli-Palestinian Health Care Reforms Seminar. JDC-Brookdale Institute, Jerusalem.

8. Rosen, B. (ed.). 1991. *The Netanyahu Commission Report: Background, Contents and Initial Reactions*. RR-24-91. JDC-Brookdale Institute, Jerusalem.

Material Distributed to Participants in Working Group A: Reorganization of the Ministry of Health

1. *State Commission of Inquiry into the Operation and Efficiency of the Healthcare System in Israel.* 1990. Report, Volume 1, Chapter 5. Government Printing Office, Jerusalem.

Material Distributed to Participants in Working Group B: Health Insurance

1. Abusaleh, A., Abuhashish, M., Abusha'aban, D., Maraheel, A. and Kassees, E. 1994. "The National Palestinian Health System: Proposed Reforms". Palestine Council of Health (PCH) Summer Seminar in Health Policy, *Reforming Health Systems*. Hebrew University-Hadassah School of Public Health, Jerusalem.

2. Chernichovsky, D. 1991. *Economic Dimensions of the Crisis in the Israeli Health-Care System: Key Principles and Proposals for Reform.* RR-28-91. Prepared within the framework of the Cooperative Program in Health Policy Research of the Government of Israel. JDC-Brookdale Institute and JDC-Israel, Jerusalem.

3. Cohen, M.A.; and Barnea, T. 1992. "Private Outlets for Public Limitations: The Rise of Commercial Health Insurance in Israel", *Journal of Health Politics, Policy and Law*, Comparative Health Policy, 17(4):783-811.

4. Ismail, N.A.; Alami, M.; and Hammad, A. 1994. *Palestinian Universal Health Insurance: Questions and Answers*. Planning and Research Centre, Jerusalem.

5. *State Commission of Inquiry into the Operation and Efficiency of the Healthcare System in Israel.* 1990. Report, Volume 1, Chapter 3. Government Printing Office, Jerusalem.

Material Distributed to Participants in Working Group C: Service Provision System

1. *State Commission of Inquiry into the Operation and Efficiency of the Healthcare System in Israel.* 1990. Report, Volume 1, Chapters 10-13. Government Printing Office, Jerusalem.

Material Distributed to Participants in Working Group D: Quality of Health Care

1. Fleishman, R.; Mizrahi, G.; Dynia, A.; Walk, D.; Shirazi, V.; and Shapira, A. 1994. "Improving Regulation of Care", *International Journal for Quality in Health Care*, 6(1):61-71.

2. Massoud, M.R.F. 1994. *Quality of Health Care in Palestine: An Analysis*. Unpublished manuscript.

3. Mozes, B.; Easterling, M.J.; Sheiner, L.B.; Melmon, K.L.; Kline, R.; Goldman, E.S.; and Brown, A.N. 1994. "Case-Mix Adjustment Using Objective Measures of Severity: The Case for Laboratory Data", *Health Services Research*, 28(6):689-712.

4. Simchen, E.; Rozin, R.; and Wax, Y. 1990. "The Israeli Study of Surgical Infection of Drains and the Risk of Wound Infection in Operations for Hernia", *Surgery, Gynecology and Obstetrics*, 170:331-337.

5. *State Commission of Inquiry into the Operation and Efficiency of the Healthcare System in Israel*. 1990. Report, Volume 1, pp. 154-160. Government Printing Office, Jerusalem.

This book is based upon a Seminar on Israeli and Palestinian Health Care Reforms organized by JDC-Israel and the JDC-Brookdale Institute, in cooperation with the Palestinian Council of Health and the Israeli Ministry of Health. It includes presentations by key figures in the Israeli and Palestinian health systems on actual and proposed health care reforms, and discussions of the difficulties each system faces in implementing these reforms. The book will be of particular interest to those involved with the planning and implementation of health care policies. However, it will also be of interest to anyone interested in recent political developments in the Middle East, and the promotion of dialogue and cooperation in the region.

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